Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Nebraska** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
B. Program Title:
HCBS Waiver for Children with Developmental Disabilities and Their Families
C. Waiver Number:NE.4154
Original Base Waiver Number: NE.4154.
D. Amendment Number:NE.4154.R05.01
E. Proposed Effective Date: *(mm/dd/yy)*
07/01/14
Approved Effective Date of Waiver being Amended: 06/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to update information related to rate determination methods, public input for the rate methodology study, service definitions impacted by the implementation of the new rate methodology, limitations to prospective individual budget amounts, flow of billings, and the billing validation process.

The following service definitions were revised to align with the rate methodology: Day Habilitation, Group home residential habilitation, Integrated Community Employment, Companion Home Residential Habilitation, Extended Family Home residential habilitation, In-home residential habilitation, and Vocational Planning habilitation service. In an effort to have consistency among waivers, Prevocational Habilitation service was terminated and the specifications were incorporated into Day Habilitation. Waiver participants that were authorized for Prevocational habilitation were authorized for Day Habilitation with no service disruption.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☑ Waiver Application	Main 6.-I, Attachmer
☐ Appendix A – Waiver Administration and Operation	
☐ Appendix B – Participant Access and Eligibility	
☑ Appendix C – Participant Services	C-3, C-4, and C-5
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☐ Appendix F – Participant Rights	
☐ Appendix G – Participant Safeguards	
☐ Appendix H	
☑ Appendix I – Financial Accountability	I-2 a., 2 b., and 3 d
☑ Appendix J – Cost-Neutrality Demonstration	J-1 and 2

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*
☐ **Modify target group(s)**
☐ **Modify Medicaid eligibility**
☑ **Add/delete services**
☑ **Revise service specifications**
☐ **Revise provider qualifications**
☐ **Increase/decrease number of participants**
☑ **Revise cost neutrality demonstration**
☐ **Add participant-direction of services**
☑ **Other**
Specify:
Revise Rate Determination Methods, Flow of Billings, Billing Validation Process, and Payments to providers in Appendix I.
Update Public Input in Main section.
Update Authorizing Signature information in Main section.
Revise Prospective Individual Budget Amount in Appendix C-4.
Add Main Attachment #2 HCB Settings Waiver Transition Plan.
Add Appendix C-5 Home and Community-Based Settings.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Nebraska** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
HCBS Waiver for Children with Developmental Disabilities and Their Families
C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NE.4154
Waiver Number:NE.4154.R05.01

Draft ID: **NE.002.05.01**

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 06/01/12
Approved Effective Date of Waiver being Amended: 06/01/12

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD), administers the HCBS waiver for children with developmental disabilities and their families. DHHS is the single state Medicaid agency.

Purpose:
DDD offers a menu of services and supports intended to allow individuals with intellectual or developmental disabilities (DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. A combination of non-specialized and specialized services are offered under this waiver for childen under the age of 21 years, and their families as appropriate, to allow choice and flexibility for individuals to purchase the services and supports that only that person may need or prefer.

Non-specialized services are services directed by the individual or family or guardian when the youth is a minor, and delivered usually by independent providers. Family -directed or participant-directed, services are intended to give the individual more control over the type of services received as well as control of the providers of those services. Non-specialized services include Homemaker, Respite, Community Living and Day Supports, Home Modifications, and Habilitative Child Care.

Specialized services are traditional habilitation services that provide residential and day habilitative training and are delivered by certified DD agency providers. Specialized services include group home habilitation, Integrated Community Employment, Prevocational Workshop habilitation, Behavioral Risk, Community Inclusion Day Habilitation, Companion Home Residential Habilitation, Extended Family Home Residential habilitation, In-Home Residential Habilitation, Medical Risk, Vocational Planning Habilitation, Workstation habilitation services, and Team Behavioral Consultation.

Goals:
Prevent institutionalization in an ICF/MR or nursing facility for individuals whose needs can be met by community based DD providers.

Promote a high quality of service delivery in community based services.

Expand participant direction of services.

Objectives:

Have a sufficient number of waiver slots each year of the waiver in order to have waiver services available to individuals who meet the eligibility criteria.

Continue to work with the Division of Medicaid and Long-Term Care, the Division of Public Health, DDD Service Coordination, and DDD Surveyor/Consultants to develop and enhance a statewide quality improvement plan.

Share and make use of all monitoring data.

Monitor provider quality assurance activities.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The following strategy was utilized for the study and implementation for the rate methodology and revisions to service definitions:

In 2009, provider agencies approached the Nebraska Legislature to request an appropriation to allow for a rate methodology study to be conducted by DDD. A legislative hearing was conducted and ultimately the funds were appropriated. A Request for Proposal (RFP) was released to attract proposals from entities who were experienced in setting rates for DD waiver services and as a result, a contractor was secured. The contractor, in collaboration with DDD and provider agencies developed a provider advisory committee and began working with a subcontractor to gain input from non-provider stakeholders. The advisory committee, the contractor and DDD had multiple in-person meetings and conference calls throughout 2010 to finalize the rate study. In addition, surveys were conducted with providers, waiver participants, family members, advocacy organization representatives, and DD Service Coordinators, and interviews were held with state representatives from 6 states. A provider cost and wage survey was developed in order to collect data in a uniform format, modeled after a survey developed for use by Wyoming's Division of DD. On Nov. 15, 2010 the survey and instructions were distributed to all certified DD agency providers to give all providers an opportunity through Dec. 10th to respond.

Six states were interviewed and researched to gather comparable information about their HCBS waivers for individuals with DD: IA, SD, WY, TN, FL, and ME, which are similar to NE in either service delivery, population and/or geography. Since DDD was interested in creating a tiered rate system, the contract modeled the methodology off of Wyoming's since their experience was relevant to the development of a methodology for DDD.

The contractor used the most recently available US Bureau of Labor Statistics wage data to review the median wage rates for a range of occupations that were similar to staff occupations at the provider agencies. Median rates for NE as well as IA, KS, SD and WY were examined to provide a point of comparison between the wage rates reported by DDD providers to the NE medians, and to show how NE compares to its peers.

In Dec. 2010, a web-based survey of non-provider stakeholders was conducted to gather their opinions about the services and rates paid to DD providers. Among stakeholder respondents were DD service recipients, family members, advocacy organization representatives, and DD Service Coordinators.

The consulting firm considered the results of the survey in its recommendations around staff wages, benefits, and training, and in June 2011, the firm met with DDD and providers to review a draft of the rates. As a result of the meeting and the additional information gathered in July, adjustments to the rate models were made and the final report was presented to DDD in Oct. 2011. Since then, the final report has been posted on the DHHS public website.

DDD has included in its annual legislative updates since 2011, the study, its impact, and the funding appropriation needed to implement the methodology. All of these documents were posted on the Department's public website. In addition, DDD has a newsletter that is mailed or emailed to providers, advocates and every single person who is eligible for DD services (those currently receiving services and those who might be waiting). The methodology was explained in the Jan., Feb., and Mar. 2010 issues in addition to updates in the Fall and Winter 2013 editions, once the funding was appropriated by the legislature.

In addition to the public input that was gathered during the development of the methodology itself, a budget request was made in 2012 by the Governor to the Legislature to implement the proposed rate methodology. All legislative hearings are publicly noticed and provider and advocates attended appropriation hearings held in early 2013. The DHHS and provider agencies testified at openly (televised and web-streamed) public hearings. In May 2013 the Nebraska Legislature included appropriation for full implementation of the rate methodology in addition to funding to ensure that every person receives a budget based on their assessed needs. The implementation date was set for July 1, 2014.

From Oct. 2013 through Jan. 2014, DDD held 60 public forums in 23 communities. Meetings announcements were sent directly to every eligible individual, invitations were sent to every provider agency, and notice was given to all DDD staff. Nearly each community had 3 forums: 1 for waiver participants, their families and advocates, 1 for provider staff, and 1 for DDD staff. A consistent power point presentation was utilized at each forum meeting to discuss waiver amendments, renewals and changes in services over the last 5 years and beyond.

As a result of the rate methodology, revisions were anticipated for service definitions to comport with the structure of the methodology. In preparation for implementation, letters were sent in Feb. and Mar. 2014 to every individual in services providing an explanation and a notice of the change in the rate structure, and the revision to their individual budget amount. Every person was given due process rights and individual teams began to meet to make adjustments to service plans as appropriate. Regularly scheduled webinars were held with service coordinators and service providers to discuss the service definitions and rate changes. On Mar. 5, 2014 the Nebraska area tribal government and agencies were notified of the submission of the waiver amendments. The letters also provided contact information for questions and comments and opportunities for public comment. No comments were received from the tribal government and agencies.

In addition, the waiver amendments, along with a summary of changes, was posted to the DDD public website on Dec.1, 2014 for 30 days.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Hovis

First Name: Pam

Title: Waiver Manager, Division of Developmental Disabilities

Agency: Nebraska Department of Health and Human Services

Address: P.O. Box 98947

Address 2: 301 Centennial Mall South

City: Lincoln

State: Nebraska

Zip: 68509-8947

Phone: (402) 471-8717 **Ext:** ☐ **TTY**

Fax: (402) 471-8792

E-mail: pam.hovis@nebraska.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Nebraska

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Miller

First Name: Courtney

Title: Deputy Director

Agency: Nebraska Department of Health and Human Services

Address: Nebraska State Office Building, 5

Address 2: 301 Cenntennial Mall South

City: Lincoln

State: Nebraska

Zip: 68509

Phone: (402) 471-9185 **Ext:** ☐ **TTY**

Fax: (402) 471-9092

E-mail: courtney.miller@nebraska.gov

Attachments

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable. This is a renewal application to an approved waiver.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required. Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The first part of this section describes the strategies that were utilized to gather and consider public input and to draft the transition plans for the 0394, 0396, and 4154 waiver amendments and the state transition plan. The second part of this section, divided by a line, specifies the state's process to bring this waiver into compliance with federal HCB settings requirements.

The state secured public input into the development of the transition plan for this waiver.

Input on Settings Requirements Prior to Draft Transition Plan(s)
Both MLTC and DDD have shared information regarding the CMS rule and related guidance (including the various webinars) since January 2014 with our stakeholders. With significant impacts anticipated to developmental disability day services, targeted collaboration with developmental disability service providers and other stakeholders was initiated. Service provider representatives even participated with Nebraska staff in our Lincoln office for one of the webinars presented by CMS.

DDD leadership has met monthly with the Nebraska Association of Service Providers (NASP) since July 2014, and NASP was provided multiple opportunities to offer informal and formal input on the transition plan and issues related to the settings challenges. In August 2014, this collaboration resulted in NASP's website publication and outreach efforts to families and provider staff most impacted by the rule to provide education and support prior to the anticipated issuance of the draft transition plan.

The new settings requirements are going to require significant organizational changes of many of our developmental disabilities service providers. Our providers have been active collaborators in this process to ensure that Nebraska continues to provide appropriate services to meet the needs of our vulnerable citizens. With the support of the Nebraska Planning Council on Developmental Disabilities, several providers have already started working with consultants to reorganize their services to promote integrated recreation and community employment, with great initial success. We share a common dedication to supporting individuals with developmental disabilities in our communities with quality services, and appreciate their collaboration through this process.

Multiple forms of public notice were utilized to inform stakeholders that the transition plan was available for public comment.

Nebraska provided a 39 day public notice and comment period (September 5, 2014 through October 14, 2014), providing for the following public input opportunities:
• Emailing to DHHS.HCBSPublicComments@nebraska.gov;
• Faxing to 402-471-9449 attention Christina Mayer;
• Mailing written comments to the Department of Health and Human Services, Attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026;
• Providing in person comments at public meetings; and/or
• Calling Christina Mayer at 1-877-867-6266.

Notice was provided in the following manner:
• Notification to the Nebraska Association of Service Providers on August 25, 2014;
• Publication in the Omaha World-Herald, a newspaper with statewide circulation on August 29, 2014;
• Delivery via U.S. postal service of a postcard announcement to all recipients of developmental disability services, as well as all individuals on DDD's eligibility registry (i.e. people who are eligible for services, but not currently receiving services) on September 1, 2014;
• Notification of Amendments and proposed State Transition Plan to Nebraska Tribal associations on September 4, 2014;
• Publication on the Nebraska Department of Health and Human Services website, with a specific HCBS Waivers State Transition Page created specifically to support this process (with links to this webpage from both the MLTC and the DDD webpages) on September 5, 2014;
• Email to all DDD staff, DD agency providers, the DD Planning Council, DD Advisory Committee, the ARC of Nebraska, Disability Rights of Nebraska, the Legislative Ombudsman's Office and the Nebraska Legislative Special Committee on Developmental Disabilities on September 5, 2014;
• Publication in the Omaha World-Herald, a newspaper with statewide circulation on September 7, 2014;
• Publication in the Munroe Meyer Institute Update, an electronic newsletter circulated broadly to stakeholders throughout Nebraska by our University Center for Excellence, on September 12, 2014.

The timeline for collecting, collating, analyzing, and incorporating public comments is identified in the Comprehensive Transition Plan Matrix. DHHS MLTC and DD staff have reviewed, incorporated, and

responded to all public comments. Responses to each public comment are included in the finalized plan.

The process to bring this waiver into compliance with federal home and community-based settings requirements is described in the state's transition plan document. The transition plan document includes a summary, background information, the CMS HCBS rule, the transition plan requirements, and the final transition plan. Links to the 0394 (Day Services waiver for adults with DD), 0396 (Comprehensive DD waiver for adults), 4154 (HCBS Waiver for Children with Developmental Disabilities and Their Families), 0187 (HCBS Waiver for Aged and Adults and Children with Disabilities), and 40199 (Traumatic Brain Injury) waivers, the Development Disabilities rules and regulations, and the Medicaid and Long Term Care rules and regulations are referenced in the transition plan as well as posted separately on the DHHS public website.

The transition plan document on the website includes a summary, background information, the CMS HCBS rule, the transition plan requirements, and the draft transition plan. Links to the 0394 (Day Services waiver for adults with DD), 0396 (Comprehensive DD waiver for adults), 4154 (HCBS Waiver for Children with Developmental Disabilities and Their Families), 0187 (HCBS Waiver for Aged and Adults and Children with Disabilities), and 40199 (Traumatic Brain Injury) waivers, the Development Disabilities rules and regulations, and the Medicaid and Long Term Care rules and regulations are referenced in the transition plan as well as posted separately on the DHHS public website.

The draft plan includes the transition plan formatted into a matrix which may be divided into separate matrices for the comprehensive plan, Developmental Disability Division (DDD) Managed Waivers (to include all developmental disability HCBS waiver services – 0394, 0396, and 4154), and Medicaid and Long-Term Care (MLTC) Managed Waivers (to include the Aged and Disabled Waiver and Traumatic Brain Injury waivers – 0187 and 40199). The DDD managed waivers and the MLTC managed waivers are further divided by task and regulatory compliance area.

The DHHS has created a comprehensive long term services and supports transition plan which is outlined in the Comprehensive Transition Plan Matrix that:
• Identifies waiver program areas for further analysis;
• Engages system stakeholders in evaluation of those areas; and
• Establishes time frames for assessment and remediation of areas that do not meet the expectation of "community-like."

The Comprehensive Transition Plan Matrix, posted on the DHHS website identifies the applicable waiver, task, regulatory compliance area, action item, anticipated start date, targeted completion date, Nebraska DHHS resources, stakeholders, and expected outcome.

Applicable waivers are categorized as all waivers, Aged and Disabled Waiver and Traumatic Brain Injury Waiver, and DD waivers. Task is categorized as identification, analysis, outreach or remediation. Regulatory compliance areas are general or other requirements, performance metrics, community integration – day services, community integration – residential, and individual rights.

The plan is posted on the DHHS website and was available for public comment for thirty-nine days from the period of September 5, 2014 to October 15, 2014. The matrices were presented at public meetings held in Kearney (September 29, 2014), Lincoln (September 30, 2014), Omaha (October 7, 2014), and Sidney (October 9, 2014).

DHHS MLTC and DDD staff collected, collated, and analyzed all public comments. All public comments were considered, and responses were prepared and are included with the final plan.

Germane to this 4154 waiver, the following service settings will be evaluated for compliance with federal HCB settings requirements: Day Habilitation, Vocational Planning Habilitation, Workstation Habilitation, Group Home Residential Habilitation, Respite, Behavioral Risk, Companion Home Residential Habilitation, Extended Family Home Residential Habilitation, and Medical Risk Services. The following DHHS resources will be utilized by DHHS staff to evaluate and identify service settings that are in compliance with the CMS HCBS rule as well as to identify service settings that are "likely not" community: Provider listings, provider site reviews and compliance surveys, participant experience surveys, self-advocate/family surveys, service coordination monitoring tools, provider self-assessments, and stakeholder meetings.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Unabbreviated additional information for MAIN REQUIREMENTS, 6-I PUBLIC INPUT:

In relation to these amendments, the following strategy was utilized for the study and implementation for the funding (rate) methodology and revisions to service definitions:

In 2009, provider agencies approached the Nebraska Legislature to request an appropriation to allow for a rate methodology study to be conducted by the Department of Health and Human Services, Division of Developmental Disabilities (DHHS-DDD). A legislative hearing was conducted and ultimately the funds were appropriated. The development of a state sanctioned Request for Proposal (RFP) was released to attract proposals from entities who were experienced in setting rates for developmental disability waiver services. As a result of the RFP process, a contractor was secured to begin the development of a new rate methodology. The contractor in collaboration with DHHS-DDD and provider agencies, developed a provider advisory committee and began working with a subcontractor to gain input from non-provider stakeholders (waiver participants, advocacy organizations, etc.). The provider advisory committee, the contractor and DHHS-DDD had multiple in-person meetings and conference calls throughout 2010 to finalize the rate study. In addition, surveys were conducted with providers, waiver participants, family members, advocacy organization representatives, and DD Service Coordinators (targeted case managers), and interviews were held with state representatives from six states.

A provider cost and wage survey was developed in order to collect data in a uniform format. The consulting firm modeled the survey and instructions after a survey developed for use by the State of Wyoming's Division of Developmental Disabilities. Prior to distributing the survey and instructions, the consulting firm reviewed the survey in detail with the provider advisory committee to gather feedback about their ability to complete the survey and understand what was being requested and made appropriate changes based on their feedback. On November 15, 2010 the survey and instructions were distributed to all certified DD agency providers to give all providers an opportunity through December 10th to respond. In July 2011, additional data was requested and upon receipt of the additional information, the consulting firm concluded that there was a representative sample of cost and wage data to conduct the rate analysis.

Six states were interviewed and researched to gather comparable information about their HCBS waivers for individuals with developmental disabilities: Iowa, South Dakota, Wyoming, Tennessee, Florida, and Maine. These states are similar to Nebraska in either service delivery, population and/or geography. Since DHHS-DDD was interested in creating a tiered rate system, the contract modeled the methodology off of the State of Wyoming's since their experience was relevant to the development of a methodology for DHHS-DDD. Tennessee and South Dakota also had methodologies that incorporated a service level score from an assessment in a tiered rate system.

In addition, the contractor used the most recently available United States Bureau of Labor Statistics wage data to review the median wage rates for a range of occupations that were similar to the staff occupations at the provider agencies. Median wage rates for Nebraska as well as Iowa, Kansas, South Dakota and Wyoming were examined. This examination not only provided a point of comparison between the wage rates reported by DDD providers to the Nebraska medians, but also showed how Nebraska compares to its peers.

In December 2010, a web-based survey of Nebraska DD stakeholders other than providers was conducted to gather their opinions about the services and rates paid to providers of developmental disabilities services. Among stakeholder respondents were Nebraskans receiving developmental disabilities services, family members of individuals receiving services, advocacy organization representatives, and DD Service Coordinators.

The consulting firm considered the results of the stakeholder survey in its recommendations around staff wages, staff benefits, and staff training and in June 2011, the firm met with DHHS-DDD and HCBS providers to review a preliminary draft of HCBS rates. As a result of the meeting and the additional information gathered in July, adjustments to the rate models were made and the final report was presented to DDD in October 2011. The final report has been posted on the DHHS public website since it was received.

DHHS-DDD has included in its annual legislative updates since 2011, the rate methodology study, its impact, and the funding appropriation needed to implement the methodology. All of these documents were posted on the Department's public website upon publication. In addition, DHHS-DDD has a newsletter that is mailed or emailed to providers, advocates and every single person who is eligible for DD services in Nebraska (those currently receiving services and those who might be waiting). The rate methodology was explained in the January 2010, February 2010, March 2010 issues in addition to updates in the Fall 2013 and Winter 2013 editions, once the funding was appropriated by the legislature.

In addition to the public input that was gathered during the development of the rate methodology itself, a budget request was made in 2012 by the Governor to the Nebraska Legislature to implement the proposed rate methodology. All legislative hearings are publicly noticed and provider and advocates attended appropriation hearings held in early 2013. The Department of Health and Human Services and provider agencies testified at openly (televised and web-streamed) public hearings. In May 2013 the Nebraska Legislature included in its appropriation full implementation of the rate methodology in addition to funding to ensure that every person in services receives a budget based on their assessed needs. The implementation date was set for July 1, 2014.

From the beginning of October 2013 to the end of January 2014 DHHS-DDD held sixty public forums across Nebraska in twenty-three communities. Meetings announcements were sent directly to every individual eligible for DD services in Nebraska (both those currently in services and those who might be waiting for a service), letters of invitation were sent to every provider agency and notice was given to all DHHS-DDD staff. Nearly each community had three forums: one for waiver participants, their families and advocates, one for provider staff and one for DHHS-DDD staff. A consistent power point presentation was utilized at each forum meeting to discuss waiver amendments, renewals and changes in services over the last five years and beyond.

As a result of the rate methodology, revisions were anticipated for service definitions to comport with the structure of the rate methodology and to also prepare for transition activities in relation to the HCB Settings Rule. In preparation for implementation of the rate methodology letters were sent in February and March 2014 to every individual in services providing an explanation and notice of the change in the rate structure and the corresponding revision to their individual budget amount. Every person was given due process rights and individual teams began to meet to make adjustments to service plans as appropriate. Regularly scheduled webinars were held with service coordinators (targeted case managers) and service providers to discuss the service definitions and rate changes. On March 5, 2014 the Nebraska area tribal government and agencies were notified notify them of the submission of the waiver amendments. The letters also provided contact information for questions and comments and

opportunities for public comment. No comments were received from the tribal government and agencies.

In addition, the waiver amendments, along with a summary of changes, was posted to the DHHS-DDD public website on December 1, 2014 for thirty days. This posting included the state transition plan.

The following strategies were utilized to draft the transition plans for the 0394, 0396, and 4154 waiver amendments and the state transition plan.

The state secured public input into the development of the transition plan for this waiver.
Input on Settings Requirements Prior to Draft Transition Plan(s)
Both MLTC and DDD have shared information regarding the CMS rule and related guidance (including the various webinars) since January 2014 with our stakeholders. With significant impacts anticipated to developmental disability day services, targeted collaboration with developmental disability service providers and other stakeholders was initiated. Service provider representatives even participated with Nebraska staff in our Lincoln office for one of the webinars presented by CMS.

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The timeline for collecting, collating, analyzing, and incorporating public comments is identified in the Comprehensive Transition Plan Matrix. DHHS MLTC and DD staff have reviewed, incorporated, and responded to all public comments. Responses to each public comment are included in the finalized plan.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   The Division of Developmental Disabilities
   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   a) DDD performs participant waiver enrollment activities; management of approved limits; monitoring of expenditures; level of care evaluations; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; execution of Medicaid provider agreements; establishment of statewide rate methodology; establishment of rules, policies, and procedures governing the waiver program; and quality improvement activities.

   b) The Nebraska State Medicaid Plan Section 1, Citation 1.1(a) outlines designation and authority and was approved by CMS November 29, 2007, with an effective date of July 1, 2007.

   c) The State Medicaid Director is the Director of the Division of Medicaid and Long Term Care (DMLTC) within the Department of Health and Human Services. Designated staff within DMLTC review reports of provider non-compliance and coordinates corrective action measures with DDD as necessary and appropriate; prepares or reviews statistical and financial data for CMS reports in collaboration with DDD and financial services staff; attends the DDD Quality Improvement (QI) Committee meetings as an active participating member; meets with DDD staff to review program and client issues as necessary and appropriate; tracks the use of Medicaid funding on the use of waiver funding relative to the budgeted amounts; monitors expenditures and budget projections; reviews the development, renewal, or amendments of HCBS waivers and has final approval authority; reviews the cost neutrality formulas developed in collaboration with

DDD and financial services staff; and submits claims for federal funds for allowable activities administered or supervised by DDD. Reports are reviewed on a monthly, quarterly, and annual basis, as well as when requested.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency
Participant waiver enrollment	☑
Waiver enrollment managed against approved limits	☑
Waiver expenditures managed against approved levels	☑
Level of care evaluation	☑
Review of Participant service plans	☑
Prior authorization of waiver services	☑
Utilization management	☑
Qualified provider enrollment	☑
Execution of Medicaid provider agreements	☑
Establishment of a statewide rate methodology	☑
Rules, policies, procedures and information development governing the waiver program	☑
Quality assurance and quality improvement activities	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of DDD QI committee meetings, the total number of meetings in which a representative of the Division of Medicaid and Long Term Care participated.

Data Source (Select one):
Other
If 'Other' is selected, specify:
meeting minutes

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The DHHS DDD Quality Improvement efforts for Community Based Services are coordinated through the DDD QI Committee (QIC) comprised of representatives from DDD Central Office, DHHS Licensure Unit, DHHS Medicaid, and DDD Service Coordination. The Division QI Committee meets on a quarterly basis and reviews aggregate data for statewide monitoring and certification to identify trends and consider statewide changes that will support service improvement. The committee also reviews data and reports on, including but not limited to: HCBS waiver service requirements, incidents, complaints, investigations, certification and review surveys, and related information reported by other DHHS divisions.

As a result of committee review, recommendations for action are submitted to the Community Based Services Administrator. The QIC reviews follow-up on actions which are implemented as a result of recommendations.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QI committee, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes show review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

This committee receives reports and information and provides/shares feedback and support to the service districts. The MLTC representative verbally reports activities of the DDD QI committee to her administrator and/or the Medicaid Director and makes all meeting minutes and reports available for their review.

A continuous evaluation component is built into the system for evaluation of utility, information received and effectiveness of strategies.

The Division's quality assurance efforts include a system to effectively monitor community-based placements and programs with appropriate protections, services, and supports. This is partially accomplished through active monitoring for individuals in services through local Service Coordination offices.

In order to assure protections, services, and supports on a systems level, the Division has established a formal certification and review process in accordance with state regulations, contract specifications, and state waiver requirements for provider agencies providing specialized services. This certification process includes certification and service reviews of community-based providers and programs by DDD Surveyor/Consultants, which are scheduled in accordance with the initial provisional, 1-year, or 2-year certifications issued by the Division. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths in specialized services provided on a statewide level. In order to ensure continued certification as a provider of DD specialized services, a formal plan of improvement is required to ensure remediation of review findings that need to be addressed. On an ongoing basis, incidents and complaints associated with certified providers which have been reported to the Division are reviewed and appropriate levels of follow-up are conducted.

QI Operational Procedures

A. Framework of QI Data Collection Process
PLAN What is Being Measured?
Why is it Being Measured?
What is the Data Source?
Who is Responsible?
DO What Will Be Done/How/Frequency?
How Will Data Be Collected (& by whom)?
How/Who Will Aggregate the Data and Generate Reports?
In What Format Will Data Be Reported?
CHECK Who/When Will Results be Reviewed and Interpreted?
To Whom Will Recommendations be Made/Timeframes?
ACT Who Will Implement/Over-See Recommended Changes?

B. Reporting Data

1. Process of Aggregating Data and Monitoring Data Trends
Data is aggregated through queries from systems where data is entered directly by the worker or reporter. These systems include Info Path, SAS, N-FOCUS, Therap, Share Point, and OnBase. For data that is not entered directly into a system, data is derived from individual source documents such as audits of files or certification reports, and manually tabulated as necessary.

2. Report Formats
Reports reflect data and information in charts, graphs, tables, and narrative formats. QI Committee minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures.

C. Communicating Results
Aggregate data is shared through the QI Committee with DD Administrative staff, Service Coordination, and other stakeholders. Data reports are submitted as requested to CMS Waiver representatives and the Department of Justice Independent Expert.

D. Using Data for Implementing Improvement
Data is reviewed on at least a quarterly basis through the QI Committee and DD Administration. Appropriate recommendations, action plans, and follow-up are included within the QI Committee minutes.

E. Assessment of the Effectiveness of the QI Process
Contributors to the assessment of the QI process can be determined through CMS audit and onsite visit reports and findings. In addition, effectiveness is also measured through the relevancy that collected data has in providing useful information on the timeliness and quality of services provided through Community Based Services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Under the area of administrative authority, individual problems are not discovered.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**
○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☑	Developmental Disability	0	20	☐
	☑	Intellectual Disability	0	20	☐
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

To be eligible for waiver services, the individual must meet additional criteria -

For individuals continuing in Special Education beyond their 21st birthday, eligibility may continue until the Special Education services end. In Nebraska, a student is entitled to complete his/her final semester, rather than leaving school on his/her 21st birthday. The waiver authorization ending date is the individual's high school graduation date.

The individual must not receive services under another 1915 (c) home and community based services waiver.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

State staff, the Disability Services Specialist which determines eligibility and prior authorizes waiver services, and the Developmental Disabilities (DD) Service Coordinator which provides case management track children's waiver participants to determine when the participant will become inelgible for the waiver.

At the annual, but no later than the semi-annual Individual and Family Support Plan (IFSP) meeting the interdisciplinary team will determine the desire and need for adult DD services, based on the participant's plan for the future, skills, abilities, needs, and availability of non-DD services and supports.

If it is determined that adult DD services will best meet the person's needs, three to four months prior to a participant aging out of the children's waiver, the standard process for new adult DD waiver referrals will be followed.

When a Disability Services Specialist (DSS) makes an initial determination that needs cannot be addressed by the adult waiver, the DSS informs the individual of the decision and the right to due process in writing. The individual's DDD Service Coordinator is also informed, so that the Team will address how the person's needs will be met through non-waiver DD services, other DHHS non-DD services, community services, natural supports, etc. The individual will continue to receive state DD services if the individual's team determines that DD services are appropriate.

There is no interruption in the individual's DD services during the transition process.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	400
Year 2	450
Year 3	475
Year 4	500
Year 5	575

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

◉ **Not applicable. The state does not reserve capacity.**

○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Children receiving DD habilitation services, who meet waiver eligibility critieria listed at Appendix B-1-a and B-1-b of this waiver application, will be given a waiver slot.

In the event that all slots were filled, the state would immediately submit an application to increase available slots to serve all eligible individuals.

All eligible individuals have comparable access to all services offered in this waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ◉ **SSI Criteria State**
   - ○ **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ **No**
   - ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☑ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ◉ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage:
- ☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☑ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☑ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

  adoption assistance children (state subsidized adoptions) 1902(a)(10)(A)(ii)(VIII)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - ◉ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - ○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

    - ☐ **A special income level equal to:**

      Select one:

      - ○ **300% of the SSI Federal Benefit Rate (FBR)**
      - ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

        Specify percentage:
      - ○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

Select one:

- ○ **100% of FPL**
- ○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- ☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
  Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

- ◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - ◉ **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - ○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ◉ **The following standard included under the State plan**

  Select one:

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The special income level for institutionalized persons**

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ◉ **A percentage of the Federal poverty level**

    Specify percentage: 100
  - ○ **Other standard included under the State Plan**

    Specify:
- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◉ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The State does not establish reasonable limits.**

○ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a

community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ◉ **A percentage of the Federal poverty level**

Specify percentage: 100

- ○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- ○ **The following formula is used to determine the needs allowance:**

Specify formula:

- ○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Disability Services Specialists are required to have a Bachelor's Degree in psychology, social work, education, public administration or a related human service field and one year experience working in the field of developmental disabilities. They must be able to communicate effectively verbally and in writing, possess excellent interpersonal skills, function as a team leader, team member, work independently, and organize/manage workload. Experience in working with people with DD and knowledge of quality assurance/improvement is preferred, but is not a requirement.

They must have knowledge of current practices in the field of DD, including service coordination, program planning, disability law, medications, the theory of normalization, and provision of habilitation services.

The following abilities are required: Communicate effectively in a variety of situations; develop working relationships with individuals with DD, their families, review team members, community professionals, program directors, agency representatives, and other groups of individuals with interests in DD; analyze behavioral data and formulate habilitation plans; and plan and organize habilitative training programs.

Skills in interviewing techniques, assessing skills, abilities, preferences, and needs and explaining services to individuals, families, and guardians are required.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

DHHS-DDD applies the following criteria to determine the need for ICF/DD services:
1. As documented by an evaluation which was made no more than three years before the initial determination of Waiver eligibility, has an intellectual disability or has a severe, chronic disability other than intellectual disability or mental illness which:
A. Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
B. Is manifested before the age of 22 years;
C. Is likely to continue indefinitely; and
D. Results in:
(1) In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:
(a) Self-care;
(b) Receptive and expressive language development and use;
(c) Learning;
(d) Mobility;
(e) Self-direction;
(f) Capacity for independent living; and
(g) Can benefit from habilitation directed toward-
a. The acquisition, retention, and improvement of self-help, socialization, and adaptive skills for the individual's maximum possible independence; or
b. For dependent individuals where no further positive growth is demonstrable, the prevention of regression or loss of current optimal functional status.

The Developmental Index is the LOC instrument that is utilized.

Allowance of an evaluation that is current within 3 years of initial eligibility is based on Nebraska Dept. of Education verification of continued eligibility for Special Education services. Special Education evaluation are completed or the need is considered every three years and are not an additional cost to the individual or the State Medicaid program. Best practice for evaluating LOC is requesting and reviewing all available Special Education evaluations or Psychological evaluations that were completed during the developmental years.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ( ) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- (●) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The Developmental Index assessment tool for waiver eligibility is comparable to the assessment tool completed for institutional placement. Both tools note strengths and needs, and current supports. Provider staff or others who are familiar with the individual complete the applicable tool.

The Developmental Index differs from the ICF LOC tool by assessing skills, abilities, and areas needing improvement for maximizing independence in the family environment and in the community, such as academic skills, socialization skills, and accessing community services.

If a former waiver participant enters the State ICF for short-term intensive behavioral treatment, the LOC is determined using the ICF LOC tool. The outcome of the determinations yielded from the Developmental Index is similar in validity and reliability to the outcome of determinations yielded from the tool completed for institutional placement.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The same process for evaluation and revaluation for the need for ICF level of care is as follows:

The Division of Developmental Disabilities employs 12 Disability Services Specialists, located across the state, to determine initial and ongoing eligibility and annual review of eligibility for HCBS waiver for children with developmental disabilities. The DDD Service Coordinator submits the following eligibility information to the Disability Services Specialist:

1. Psychological evaluation current within 3 years of initial eligibility determination.

2. Individual and Family Support Plan(service plan). The Individual and Family Support Plan (IFSP) must identify the needs and preferences of the individual and specify how those needs and

preferences will be addressed. The IFSP identifies the individual and family's immediate and future goals, specialized DD services and supports, non-specialized services and supports, as well as services and supports to be provided by other non-DDD funded resources (including medical services and supports). The annual IPP documents specialized DD provider(s); non-specialized providers; authorized funding amounts and/or units of services; and habilitation/training goals and strategies. The IFSP is developed by an interdisciplinary team consisting of the individual; the assigned DDD Service Coordinator; legal representative; family; specialized provider staff; and non-specialized providers, other professionals, advocates, and/or friends as requested by the individual or legal representative. The IFSP is reviewed initially and annually thereafter, and when a participant's changing circumstances may affect waiver eligibility.

3. Semi-annual IFSP and all special meetings or addenda to the IFSP. Semi-annually and as needed the team meets to review progress and make any necessary changes in the individual's provider(s), services, environment, etc.

4. Developmental Index current within one year of initial eligibility and annual review of eligibility. The Developmental Index is specific to waiver eligibility and identifies an individual's skills, abilities, and areas needing improvement. The Developmental Index is completed by the individual's Service Coordinator and provider staff and reviewed at the IPP meeting. If there are discrepancies between/among the assessments, these discrepancies must be clarified in the IFSP.

The DDD Service Coordinator submits the above eligibility information to the Disability Services Specialist. The DSS verifies Medicaid eligibility, then reviews the information to determine whether the individual meets ICF level of care criteria and therefore waiver eligibility. The Disability Services Specialist looks at the individual's assessed abilities and needs; how the assessed needs will or are being met, including DD services, Medicaid State Plan services, generic non-Medicaid community services and supports, and family supports, and considers whether the individual would require the services of an ICF if HCB services were not available. If the individual is determined eligible for the waiver, the individual or legal representative is given the choice between home and community based waiver services and ICF services, and the Disability Services Specialist will prior authorize the waiver services if waiver services are chosen.

The Disability Services Specialist reviews for eligibility on an ongoing basis, and completes an annual review of the IFSP and Developmental Index, and verifies Medicaid eligibility.

At any point, the Disability Services Specialist may ask for additional information and clarification.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Disability Services Specialists use the following procedures to ensure timely reevaluations of level of care:
Tickler files, such as Excel spreadsheets, and computer system alerts; and the processes that are a component part of service coordination.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Disabilities Services Specialists, who are responsible for the performance of evaluations and reevaluations of level of care, maintain records. The records are maintained electronically and within the office of the Disability Services Specialist.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number of new waiver eligibility determinations completed by the disability services specialist within 2 weeks of receipt of all required information.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination Worksheet

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually, or as determined by the DDD QI committee

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who have had an annual LOC re-determination within one year of their initial LOC evaluation and within 1 year of their last annual LOC evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination Worksheet

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☑ **Other** Specify: as determined by the state DDD QI committee

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of LOC determinations, the number of LOC redeterminations that were completed accurately according to the processes and instruments described in the approved waiver and according to the approved description to determine participant level of care.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination Worksheet

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually, or as determined by the state DDD QI committee

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Annual redetermination of eligibility is completed for all (100%) waiver recipients. The timeline for completion of the annual review is within 60 days of the individual's IFSP meeting, but no later than 120 days after the meeting. Each of the Disability Services Specialists (DSS) has created a tickler system to keep track of when annual reviews are due, based on the individual's waiver year, and DDD Service Coordination policies and procedures include components related to waiver eligibility and review requirements. Annually, the DSS reviews the annual IFSP, the Developmental Index (LOC assessment tool), and Medicaid information, and completes a standardized worksheet.

b. **Methods for Remediation/Fixing Individual Problems**

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The state monitors level of care decisions and takes action to address inappropriate LOC determinations, which may include failure to determine eligibility, failure to determine eligibility within established timelines, inaccurate determinations, and missing or incomplete documentation. The state monitors the performance of the DSSs through self measurement and reporting to their Supervisor. The following performance measurements are self reported by marking Yes or No for each initial eligibility determination:
Eligibility is completed within two weeks of receipt of all required information.
HCB waiver services are authorized within one week of eligibility determination.
Eligibility review conducted within one year of new determination/annual redetermination.
When applicable, changes in authorization completed within two weeks.

The DSS' Supervisor evaluates the performance of the staff, utilizing the self reports and data available at the central office level for identification of technical assistance/training needs for all of the DSS and for identification of systems or procedural changes.

Monthly quality assurance reports are reviewed at the local level to ensure continued Medicaid and waiver eligibility and accurate service authorizations for participants. The monthly quality assurance reports are generated by NFOCUS, Nebraska's current electronic authorization and payment system, and posted on an intra-agency website for access by DDD staff. The NFOCUS system also generates automatic alerts of upcoming actions pertaining to individual cases. The DSSs and SCs receive these alerts 30 to 60 days ahead of time to warn of actions such as Medicaid closures, service authorization closures, and expiration of provider agreements.

DSSs, service coordinators, and their Supervisors review the reports and alerts and take appropriate action as needed on individual cases. Examples of such action may be assisting the individual with recertification of Medicaid, changing the IFSP to address a change in circumstances, submitting a service authorization for a change in services, determining waiver eligibility for new Medicaid recipients, etc.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually, or as determined by the DDD QI management staff

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Nebraska waiver participants are afforded choice between waiver services and institutional care. Waiver participants are also afforded choice of providers and choice of services to meet their needs and preferences.

Choice of ICF or waiver services is documented on Form DDD-1 "Consent Form". Information about Nebraska's DD waiver services, waiver providers, and freedom of choice is provided verbally and in written materials to assist the individual or legal representative in understanding waiver services, funding of his/her services, and the roles and responsibilities of the participants (the individual, family, guardian, DHHS staff, etc.). This information is provided by the participant's Service Coordinator or the Disability Services Specialist.

A signature for consent, documenting that waiver participant's choice is to receive community based waiver services over services in an institutional setting, is obtained upon initial determination of waiver eligibility and is kept in the individual's waiver file. Form DDD-1 explains the right and process to appeal.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Form DDD-1, the consent form, is kept in the individual waiver file maintained by the Disability Services Specialist. The records are maintained electronically and within the office of the Disability Services Specialist.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following methods are utilized to provide meaningful access to services by individuals with limited English proficiency;

• Oral language assistance:
• Translation of written materials;
• Foreign language placards, posters, etc.;
• Second language hiring qualifications; and
• Availability of translators, including sign language.

Oral language assistance is offered through services such as interpreters under contract with DHHS and phone interpretor services.

The DHHS public website includes language translations via Google Language Tools for Arabic, Chinese Simplified, Croation, Czech, French, German, Italian, Japanese, Korean, Norwegian, Polish, Portuguese, Russian, and Spanish.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Day Habilitation
Statutory Service	Group Home Residential Habilitation
Statutory Service	Homemaker
Statutory Service	Integrated Community Employment - Individual Employment Support
Statutory Service	Respite
Other Service	Behavioral Risk Service

Service Type	Service		
Other Service	Community Living and Day Supports		
Other Service	Companion Home Residential Habilitation		
Other Service	Extended Family Home Residential Habilitation		
Other Service	Habilitative Child Care		
Other Service	Home modifications		
Other Service	In-Home Residential Habilitation		
Other Service	Medical Risk services		
Other Service	Team Behavioral Consultation		
Other Service	Vocational Planning habilitation service		
Other Service	Workstation habilitation services		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day Habilitation services are formalized training and staff supports that take place in a non-residential setting separate from the individual's private residence or other residential living arrangement. Day Habilitation services only take place during times when a child is not attending school due to school not being in session (i.e., summer breaks and/or scheduled school holidays, in-service days, etc.). Day Habilitation services are scheduled activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, community living, and employment. Day Habilitation services may be provided to individuals that may not have a clear plan for employment and are therefore not currently seeking to join the general work force. Training activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice necessary to participate successfully in community living. Individuals receiving day habilitation services are integrated into the community to the greatest extent possible.

Day Habilitation may be delivered in integrated community settings or in provider owned and operated settings for a portion of the typical workday. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Staff support is continuous, that is, staff are present at all times the individual is present. Continuous day services are expected to be available for no less than seven hours per day. The provider may operate a location where individuals come to check-in prior to participating in integrated activities and/or to participate in a variety of daily activities related to greater community living. Provider owned and controlled settings may also allow for individuals who are experiencing short-term medical or behavioral crisis a location to participate in activities that are outside the residence.

The teaching and supports offered under Day Habilitation services prepare an individual for paid or unpaid work experiences and competitive employment. When compensated, individuals may be paid at less than 50 percent of the minimum wage. Habilitation, or teaching and supporting, may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Services are generally not job-task oriented but instead are directed at improvement of basic skills such as attention span and motor skills, and not explicit employment objectives.

The activities, services, supports, and strategies are documented in the service plan, and the frequency and duration for which the services are delivered will be based on the service plan. Day habilitation services will focus on enabling the individual to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies listed in the service plan. In addition, the services and supports may reinforce skills taught in therapy, counseling sessions, or other settings. This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.

For individuals with degenerative conditions, Day Habilitation services may include training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Meals provided as part of these services do not constitute a full nutritional regiment and as applicable, physical nutritional management plans must be implemented as documented in the service plan. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Individuals that choose Day Habilitation may also choose Community Living and Day Supports but these services may not be billed during the same period of the day. Daily rates are available for Day Habilitation services when the person receives this service for four or more consecutive hours. Hourly rates are also available for times when the individual might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate. CLDS can only be billed at an hourly rate on days when no daily rate is billed for Day Habilitation. When both services are provided in one workday, both Day Habilitation services and CLDS are billed in hours.

Transportation may be provided between the individual's place of residence and the habilitation (teaching and supporting) service site or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation services in more than one place. The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified DD agency provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
certified DD agency provider
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify)*:
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD)
Frequency of Verification:
Every one or two years as applicable

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Residential Habilitation
Alternate Service Title (if any):
Group Home Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:
Group home residential habilitation (teaching and supporting) services are formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making, and

household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Group home residential services also includes personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan, also called the individual program plan (IPP) or individual support plan (ISP).

Group home residential habilitation (teaching and supporting) services are continuous services and are delivered in provider operated or controlled settings, such as a home with three or less individuals with DD, or a licensed Center for persons with Developmental Disabilities (CDD) with four or more individuals with DD. Rental agreements with and payment for room and board to a DD provider must be treated as landlord-tenant agreements and all applicable state and local laws must be followed.
Staff support is continuous, that is, staff must be present and awake during the times that individuals are present and awake. Continuous residential services are expected to be available for no less than eleven hours. Generally, residential services will begin at 6:00 am each day. Daily rates are available for Group home residential services when the person receives this service for four or more hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75). The need for and intensity of direct staff support during overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff must be documented in each individual's service plan. As applicable, the type of awake overnight supervision or assistance that is required must be documented in the individual's service plan. As applicable, when the individual does not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

When the provider claims for overnight awake or overnight asleep staffing, the staff must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

The method by which the cost of room and board is excluded from payment for group home residential habilitation (teaching and supporting) services is specified in Appendix I-5.

Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of group home residential habilitation (teaching and supporting) services and the cost of this transportation is included in the rate paid to providers of residential habilitation (teaching and supporting) services. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed.

Day services and intensive behavioral interventions are not components of this service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payments for group home residential services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for group home residential services does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified community based DD provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Group Home Residential Habilitation

Provider Category:
Agency
Provider Type:
certified community based DD provider
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:

Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:

DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Homemaker
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Homemaker services are the general household activities necessary for maintaining and operating the child's family home to allow the usual caregiver to attend to and nurture the individual. The intent of Homemaker services is to allow the usual caregiver to meet the personal, social, and psychological needs of a growing developing child. Further, the intent of Homemaker services is to allow the caregiver to support and nurture self-direction, independence, and participation in integrated educational and community activities.
Any or all homemaker components may be provided to the child or the child's family as documented in the IFSP. These include:
Escort Service: A child receiving escort services is accompanied to obtain services, other than education, such as medical, dental, therapies, and behavioral health counseling because the child is unable to travel or wait alone.
Errand Service: Providing service in relation to needs described for escort service when not generally accompanied by the child, such as picking up the child's prescription or specialized equipment.
Essential Shopping: Obtaining clothing or personal care items for the child, or food for the family.
Food Preparation: Preparing family meals as necessary.
Housekeeping Activities: General in home cleaning and care of household equipment, appliances, or furnishings.
Laundry Service: Washing, drying, ironing, folding, and storing laundry in the family home; or utilizing laundromat services on behalf of the child or child's family.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Homemaker services are available only to children residing in their family homes.

The family must supply the necessary food and kitchen equipment for food preparation.
The family must supply necessary cleaning products and equipment.
The family must supply necessary laundry products and equipment or machine use fees when a provider of laundry services washes, dries, irons, folds, or stores laundry for the child or the child's family.

Homemaker services are not intended to duplicate or replace other supports available to the individual, including natural supports and state or federally funded services. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

To avoid duplicative billing, Homemaker services will not be prior authorized when the waiver participant is receiving in-home residential habilitation that focuses on teaching the individual homemaker components such as laundry, essential shopping, meal preparation, general house cleaning or home maintenance activities.

Homemaker services cannot exceed 10 hours per week or 520 hours per waiver year.

Unused homemaker hours are not carried over into the next waiver year.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	independent contracted provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Homemaker

Provider Category:
Individual
Provider Type:
independent contracted provider
Provider Qualifications
License *(specify):*
Licensing is not a requirement to be a qualified individual homemaker provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual homemaker provider.
Other Standard *(specify):*
Must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 10-000:

A provider of this service must:
1. Be age 18 or older;
2. Not be a member of the individual's immediate household;
3. Not be the usual non-paid caregiver or legally responsible relative;
4. Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
5. Not be the guardian;
6. Be authorized to work in the United States; and
7. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

Verification of Provider Qualifications
Entity Responsible for Verification:
Health and Human Services staff are responsible for verification.
Frequency of Verification:
annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Supported Employment
Alternate Service Title (if any):
Integrated Community Employment - Individual Employment Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Integrated community employment (ICE) is Individual Employment Support consisting of intermittent formalized training and staff supports that are needed by an individual to acquire and maintain a job/position in the general workforce at or above the state's minimum wage. The outcome of this service is sustained paid employment in an integrated setting in the general workforce that meets personal and career goals, as documented in the IFSP. ICE services are person-centered and team supported to address the individual's particular needs for ongoing or intermittent habilitation.

Integrated community employment (ICE) service is individual employment support consisting of intermittent formalized training and staff supports that are needed by an individual to acquire and maintain a job/position in the general workforce at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment in an integrated setting in the general workforce that meets personal and career goals, as documented in the individual service plan. ICE services are person-centered and team supported to address the individual's particular needs for ongoing or intermittent habilitation (teaching and supporting) throughout stabilization services and extended integrated community employment services and supports. Intermittent services imply that staff support is provided when the services and supports are needed. ICE, as an intermittent service, can only be billed in half, quarter hours, or full hour increments. An hour of service equates to one clock hour.

Integrated Community Employment is delivered at regular job sites in the community where people without disabilities work and the setting is not operated or controlled by a DD provider. Staff support is intermittent and one-on-one and the DD provider staff is not there during all hours that the individual is present.

ICE services include habilitation (teaching and supporting) that is outcome based and focused to sustain paid work by individuals and is designed to obtain, maintain, or advance employment. Intensive direct habilitation (teaching and supporting) will be designed to provide the individual with face to face instruction necessary to learn explicit work-related responsibilities and skills, as well as appropriate work behavior.

ICE services enable individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Support may involve assisting the individual in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

ICE services are primarily provided away from the home, in a non-residential setting, during typical working hours. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Discreet habilitation (teaching and supporting) during typical working hours is allowed in preparation for leaving the place where the person lives. Intermittent face to face individualized habilitation (teaching and supporting) is provided to assist the individual in maintaining employment. Habilitation (teaching and supporting) goals and strategies must be identified in the service plan and specify in a measurable manner, the services to be provided to meet the preferences and needs of the individual.

This service is not small group employment support. ICE services do not include employment in group settings such as Workstation services, enclaves, classroom settings, or provider-owned and controlled fixed site Day Habilitation settings. In addition, it does not include services provided in provider-controlled residential environments such as Group Homes or Extended Family

Homes.

Transportation may be provided between the individual's place of residence and the habilitation (teaching and supporting) service site or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation (teaching and supporting) services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
• Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
• Payments that are passed through to users of supported employment programs; or
• Payments for training that is not directly related to an individual's integrated community employment services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan, also called the individual and family support plan (IFSP), individual program plan (IPP), or individual support plan (ISP).

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Additional staffing may be required when the youth reside in a group home or extended family home residential habilitation service settings and is not receiving educational services.

ICE services require at least 40 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue reimbursement at the ICE rate as long as the minimum total number of hours worked for the last three months (including the current month) is more than 120 hours of work (or an average of 40 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 40 hours of employment per month.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Integrated Community Employment - Individual Employment Support

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify)*:
The CBDD provider agency must be a certified and contracted provider in accordance with applicable titles of the Nebraska Administrative Code.

The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:

Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service

Service:
Respite
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Respite is the temporary, intermittent relief to the usual non-paid caregiver(s) from the continuous support and care of the individual to allow the caregiver to pursue personal, social, and recreational activities such as personal appointments, shopping, attending support groups, club meetings, and religious services, or going to movies, restaurant, or on vacations. Components of the respite service are supervision, tasks related to the individual's physical and psychological needs, and social/recreational activities. Services are provided on a short-term basis because of the absence or need for relief of those unpaid persons who normally provide care for the individual. These services may be provided in the individual's living situation and/or in the community in a provider-operated residential setting. The tasks and interventions to be performed to meet the needs of the individual are documented in the IFSP.

Meals provided as part of these services shall not constitute a full nutritional regimen (3 meals per day).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite is available only to those individuals who live with their usual non-paid caregiver(s). The term "usual non-paid caregiver" means a person who resides with the individual, is not paid to provide services, and is responsible on a 24-hour per day basis for the care and supervision of the individual.

Payment for respite does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Respite cannot be provided by members of the individual's immediate household.

Respite is available only to children residing in their family home.

Respite services cannot be used as adult/child care while the parents work or attend school. Respite cannot be delivered at the same time as the delivery of Group Home residential habilitation services, Companion Home Residential Habilitation services, Community Living and Day Supports, Extended Family Home Residential Habilitation services, In-Home Residential Habilitation services, Day Habilitation services, Workstation Habilitation services, Vocational Planning Habilitation services, Integrated Community Employment services, or Habilitative Child Care services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

The amount of authorized services for respite services is not determined using the objective assessment process.

Respite cannot exceed 30 days per individual waiver year and unused respite hours are not carried over into the next waiver year.

When choosing this waiver, respite funding cannot be requested from other DHHS programs in the Divisions of Medicaid and Long-Term Care, Children and Family Services, Behavioral Health, or Public Health.

Federal financial participation is not claimed for the cost of room and board.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	independent contracted provider
Agency	community based developmental disabilities contracted provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
independent contracted provider
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual respite provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 Chapters 9 and 10:
A provider of this service must:

1. Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the child and family requests a younger provider, DHHS staff may authorize a provider no younger than age 18, considering the following:
a. The functioning level of the child;
b. The availability of back-up assistance; and
c. The capacity of the provider to meet the child's needs in the case of an emergency; and
d. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.
2. Not be a member of the individual's immediate household;
3. Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
4. Not be the usual non-paid caregiver or legally responsible relative;
5. Not be the guardian;
6. Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner;
7. Have knowledge of basic first aid skills and of emergency responses;
8. Be authorized to work in the United States; and
9. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
a) Assume responsibility;
b) Follow emergency procedures;
c) Maintain schedules; and
d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

If Respite is provided outside of the family home, it is recommended that the family visit the facility or home in which the service is to be provided and agree to the provision of services in that location. The provider must ensure that:
1. The home/facility is architecturally designed to accommodate the needs of the individuals being served;
2. An operable phone and emergency phone numbers are available;
3. The home/facility is accessible to the individual, clean, in good repair, free from hazards, and free of rodents and insects;
4. The home/facility is equipped to provide comfortable temperature and ventilation conditions.
5. The toilet facilities are clean and in working order;
6. The eating areas and equipment are clean and in good repair;
7. The home/facility is free from fire hazards;
8. The furnace and water heater are located safely;
9. Firearms are in a locked unit;
10. Medications and poisons are inaccessible; and
11. Household pets have all necessary vaccinations.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Human Services agency staff.

Frequency of Verification:
Annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
community based developmental disabilities contracted provider

Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 8-000 Respite Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act

Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).

Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Risk Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Behavioral risk services are provided to individuals with complex behavioral needs that require continuing care and treatment. Behavioral risk services may be required when behaviors place the individual and/or others at risk of harm and may include actual, attempted, or threatened physical harm to oneself and/or others. This includes implicit threats, which is defined as statements and/or acts that reasonably induce fear of physical harm to others. Additionally, examples of behaviors placing oneself and/or others at risk of harm include self-directed actions intended to cause tissue damage, medication non-compliance, destruction of other people's belongings, elopement, and contact with the legal system for the previously mentioned behaviors, as well as other law-breaking behaviors (e.g., stealing, vandalism).

The need for behavioral risk services will be determined by designated staff at Division of Developmental Disabilities (DDD) central office. A risk screen is completed by the individual's service plan team to assist the team in planning, as a guide in giving adequate consideration to risk factors, or at the request of DDD central office. If the risk screen indicates an individual may present a risk of harm to oneself and/or others, the individual may be referred to DD central office for a formal risk assessment.

A risk assessment identifies, evaluates, and prioritizes interventions to implement or attempt to manage/reduce risk. The risk assessment will include the following: description, likelihood, frequency, duration, intensity, imminence, and incapacitation. Additionally, it includes an examination of the function of violence, for example, perceptual distortions, antisocial attitudes, irrational beliefs, labile affect, or interpersonal stressors. A risk assessment will also evaluate "buffering" conditions that reduce the likelihood of risk, for example, residential and day habilitation (teaching and supporting) services, non-DD therapeutic services, an individual's personal strengths (e.g., motivation), support system (e.g., family and friends), ability to establish pro-social judgment, and history of adverse life events.

If DDD central office staff concludes an individual presents a moderate to high risk of harm to oneself and/or others, the individual will be eligible for behavioral risk services. Should an individual present with a dual diagnosis of DD and MI and their risk is a result of issues stemming from Axis I, primary diagnosis of severe persistent mental illness, then the individual will be referred for behavioral health services. Behavioral risk services are not intended to supplant other behavioral health services such as, but not limited to psychiatry, counseling, or individual or group therapy.

Behavioral risk services are provider-operated services, considered to be continuous (24/7) services, and include residential habilitation (teaching and supporting) services, day habilitation (teaching and supporting) services, intensive behavioral supports, ongoing safety supervision, and ongoing supports. Behavioral risk services are all-inclusive, meaning that an individual cannot receive these services in combination with another DD waiver service. The provision of behavioral risk services will be under the direction of a supervising mental health practitioner. Behavioral risk services are furnished as specified in the individual program plan. Staffing ratios are flexible and commensurate to meeting the needs of the individuals.

Intensive behavioral intervention strategies and supports require ongoing assessment, professional judgment, and treatment based on ongoing assessment. The provider must have a licensed independent mental health practitioner on staff to oversee the delivery of behavioral risk services by unlicensed direct support professionals.

Residential habilitation (teaching and supporting) services delivered as an inclusive component of this service include formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training, intensive behavioral supports, and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.

Day habilitation (teaching and supporting) services delivered as an inclusive component of this service include formalized training and staff supports which focus on the acquisition of work skills and appropriate work behavior. Behavioral risk day habilitation (teaching and supporting) also includes intensive behavioral supports that focus on the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum integration, inclusion, and personal accomplishment in the working community. Day habilitation (teaching and supporting) services, such as Day Habilitation, workstations, vocational planning services, or integrated community employment are provided away from the home, in a non-residential setting, during typical working hours. Discreet habilitation (teaching and supporting) in preparation for leaving the residential setting during typical working hours is allowed.

Intervention strategies for the delivery of habilitation (teaching and supporting), intensive behavioral supports, ongoing safety supervision, and ongoing supports are determined by the service plan team in conjunction with the supervising mental health practitioner and must be documented in the service plan. Interventions will be based on the individual's assessed needs and, as applicable, will include the following: staff objectives/ safety plans for preventing and/or stopping behaviors that are harmful to the individual or others; habilitation (teaching and supporting) to address acceptable communication of needs and preferences, coping, social, and problem-solving skills; residential and vocational settings, environmental and architectural factors, and location of service delivery; collaboration with behavioral health efforts to meet mental health needs (e.g., counseling, individual/ group psychotherapy, psychotropic medications); and supervision and monitoring strategies, including the type and amount of supervision, law enforcement contacts, provider monitoring responsibilities, and service coordination responsibilities. Restrictive interventions to ensure the safety of the individual and others must be reviewed at every service plan meeting.

When determined appropriate by the service plan team and supervising practitioner, a plan to reduce the intensity of Behavioral Risk Services must be developed and upon request, provided to DDD central office.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Behavioral risk services are not participant directed. The amount of authorized services for behavioral risk services may not be determined using the objective assessment process. The rate for Behavioral Risk services includes a 'difficulty of care' factor such as additional compensation for supervising practitioners on staff or under contract.

Payments for behavioral risk services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for behavioral risk services does not include payments made, directly or indirectly, to members of the individual's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Behavioral risk services are all-inclusive, meaning that an individual cannot receive these services in combination with another DD waiver service. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Behavioral Risk services are limited to individuals that reside in a group home and extended family home residential habilitation service settings. Additional staffing may be required when the youth is not receiving educational services. Behavioral Risk services are not available to individuals that receive Companion Home Residential Habilitation services and in-home residential habilitation services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Risk Service

Provider Category:
Agency
Provider Type:
certified CBDD provider
Provider Qualifications
License *(specify)*:
Mental health practitioners require a license and must hold the license in accordance with applicable state laws.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120
Certificate *(specify)*:
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify)*:
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Living and Day Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
CLDS provides the necessary assistance and supports to meet the daily needs and preferences of the individual. CLDS is provided with the individual present to ensure adequate functioning in the individual's home, as well as assisting the individual to participate in a wide range of activities outside the home. CLDS may also provide the necessary assistance and supports to meet the employment and/or day service needs of the individual in integrated, community settings. The Community Living and Day Supports service includes the following components:

1. Individual assistance with hygiene, bathing, eating, dressing, grooming, toileting, transferring, or basic first aid.

2. Supervision and monitoring for the purpose of ensuring the individual's health and safety.

3. Supports to enable the individual to access the community. This may include someone hired to accompany and support the individual in all types of community settings.

4. Supports to assist the individual to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.

5. Supports to assist the individual in identifying and sustaining a personal support network of family, friends, and associates.

6. Household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry.

7. Home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment.

8. Supports to enable the individual to maintain or obtain employment. This may include someone hired to accompany and support the individual in an integrated work setting. Integrated settings are those considered as available to all members of the community. The employment supports are delivered informally. That is, the provider is not required to write formal training programs with long term goals, short term objectives, strategies, and data collection methodology. The supports delivered under CLDS could be considered "natural teaching moments."

9. Supports to enable the individual to access services and opportunities available in community settings. This may include accompanying the participant to and facilitating participation in general community activities, community volunteer work, and services provided in community settings such as senior centers and adult day centers. CLDS must not be duplicative or replace other supports available to the individual. The services provided under CLDS are different from those provided under Targeted Case Management in that the CLDS provider supports the individual by providing transportation if necessary and remaining with the individual during receipt of the services and community activities. Nebraska service coordinators do not provide direct services and supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
CLDS cannot be provided by the usual caregiver. The term "usual caregiver" means a person(s) who resides with the child, is not paid to provide services, and is responsible for the care and supervision of the child on a 24-hour basis.

Payment for CLDS does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Assistance with personal care needs or household activities is available only to those individuals who live with an unpaid caregiver.

CLDS is not intended to duplicate or replace other supports available to the individual, including natural supports and state or federally funded services.

Household activities and home maintenance activities are for the purpose of fulfilling duties the individual would be expected to do to contribute to the operation of the household, if it were not for the individual's disability.

Homemaker services cannot be authorized when an individual receives Community Living and Day Supports.

Routine health care supports may be furnished to the extent permitted under Nebraska state law.

Individual assistance with money management and personal finances may be provided, but the provider cannot act as the representative payee.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement and as required by law, will be examined prior to any authorization of home maintenance services under CLDS.

The individual must supply necessary cleaning products and equipment when a provider cleans or cares for household equipment, appliances, or furnishings in the individual's home.

Payment for the work performed by the individual is the responsibility of the employer. Covered services do not include those provided in specialized developmental disability provider settings, workstations, or supported employment services.

Supports provided under CLDS must be those that are above and beyond the usual services provided in such a setting and not duplicate services expected to be the responsibility of immediate household members, a senior center, adult day center, or employer.

The individual must supply necessary cleaning products and equipment or money for a Laundromat when a provider cleans or cares for the individual's clothing.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. CLDS cannot be delivered at the same time as the delivery of Group Home residential habilitation services, Companion Home Residential Habilitation services, Extended Family Home Residential Habilitation services, In-Home Residential Habilitation services, Workstation Habilitation services, Day Habilitation services, Vocational Planning Habilitation services, Integrated Community Employment services, Respite, or Habilitative Child Care services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Waiver services will not be furnished to a child while s/he is an inpatient of a hospital, nursing facility, or ICF/DD. Room and board is not included as a cost that is reimbursed under the children's waiver.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	community-based DD agency provider
Individual	independent

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living and Day Supports

Provider Category:
Agency
Provider Type:
community-based DD agency provider
Provider Qualifications
License *(specify):*
Licensing is not a requirement to be a qualified individual CLDS provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual CLDS provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

The provider must meet applicable standards as described in NAC 404 Chapters 10-000.

In addition, a provider of this service must:

Not be the guardian; and

Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living and Day Supports

Provider Category:
Individual
Provider Type:
independent
Provider Qualifications
License *(specify):*
Licensing is not a requirement to be a qualified individual CLDS provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual CLDS provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 Chapters 9 and 10:
A provider of this service must:

1. Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the child and family requests a younger provider, DHHS staff may authorize a provider no younger than age 18, considering the following:
a. The functioning level of the child;
b. The availability of back-up assistance; and
c. The capacity of the provider to meet the child's needs in the case of an emergency; and
d. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.
2. Not be a member of the individual's immediate household;
3. Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
4. Not be the usual non-paid caregiver or legally responsible relative;
5. Not be the guardian;
6. Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner;
7. Have knowledge of basic first aid skills and of emergency responses;
8. Be authorized to work in the United States; and
9. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
a) Assume responsibility;
b) Follow emergency procedures;
c) Maintain schedules; and
d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS agency staff
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Companion Home Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Companion home services consist of residential habilitation (teaching and supporting) services delivered as formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Companion home services may also include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present. Training or teaching and staff supports (habilitation) are delivered face-to-face in the individual's home and in the community.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Companion home residential habilitation (teaching and supporting) services may be provided to no more than two other individuals in a residence that is under the control and direction of the individual(s) and can be delivered intermittently or continuously. A companion home may be an apartment, a house, a condominium, or a townhouse which the individual owns or rents. The provider of residential habilitation (teaching and supporting) services in a companion home must be able to document that the individual freely chose their residential setting and housemates and that the lease or mortgage is under the control of the individual.

For continuous companion home residential habilitation (teaching and supporting) services, the provider staff must be present and awake during the times that individuals are present and awake. The need for and intensity of direct staff support during overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff must be documented in each individual's service plan. As applicable, the type of awake overnight supervision or assistance that is required must be documented in the individual's service plan. As applicable, when the individual does not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

When the provider claims for overnight awake or overnight asleep staffing, the staff must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan. Continuous residential services are expected to be available for no less than eleven hours with six hours of overnight. Generally, residential services will begin at 6:00 am each day. Daily rates are available when the person receives this service for four or more hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Companion home residential habilitation (teaching and supporting) services may be delivered intermittently. Intermittent services imply that community based DD provider staff support is provided when the services and supports are needed and are delivered face-to-face intermittently available to deliver habilitation (teaching and supporting) to the person receiving services in the family home or in the community. Intermittent companion home residential habilitation (teaching and supporting) services are based on the individual's preferences and assessed needs, and must be documented in the service plan. Intermittent residential services are delivered in accordance with the needs and preferences of the individual, and must be documented in the service plan. Intermittent residential services are billed in hourly rates and an hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Continuous AND intermittent residential services cannot be billed on the same day when the provider is going to bill the daily rate.

Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of companion home residential habilitation (teaching and supporting) services and the cost of this transportation is included in the rate paid to providers of residential habilitation (teaching and supporting) services. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed.

The method by which the cost of room and board is excluded from payment for residential habilitation is specified in Appendix I-5.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payments made by the State for companion home residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for companion home residential habilitation does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences, to the extent possible, as documented in the service plan.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified community based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion Home Residential Habilitation

Provider Category:
Agency
Provider Type:
certified community based DD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Extended Family Home Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Extended family home residential habilitation (teaching and supporting) service is formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Residential habilitation (teaching and supporting) services provided in a single family home setting are called extended family home (EFH) residential habilitation (teaching and supporting) services. The home is not owned by the individual and is rented or owned by the employee or sub-contractor of the DD provider agency. EFH residential habilitation (teaching and supporting) services are delivered by an employee of the DD provider agency or under a subcontract with a DD provider agency and are continuous services. Continuous residential services are expected to be available for no less than eleven hours. Generally, residential services will begin at 6:00 am each day. Daily rates are available for EFH residential services when the person receives this service for four or more hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

EFH residential habilitation (teaching and supporting) services are services provided in a setting where the individual and the EFH provider resides and the EFH provider is on-site and immediately available at all times to the individual receiving services, including during the individual's sleep time. The EFH provider must be present and awake during the times the individual is present and awake.

Six hours of overnight staffing are built into the overnight awake and overnight asleep rate for EFH residential habilitation (teaching and supporting) services. The EFH provider may be sleeping, unless awake overnight supervision or assistance is required as documented in the individual's program plan, and must be present to respond immediately to individuals' needs and emergencies. Overnight staffing may or may not provide formal training or intervention when the person awakens during the night. The need for formal training or interventions during

overnight hours is based on the individual's assessed needs, and how the needs will be addressed, which may include explicit formal training or interventions, assistance with personal needs, and/or health maintenance activities must be documented in the service plan.

The method by which the cost of room and board is excluded from payment for residential habilitation is specified in Appendix I-5.

Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of EFH residential habilitation (teaching and supporting) services and the cost of this transportation is included in the rate paid to providers of residential habilitation (teaching and supporting) services. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
A maximum of three individuals with DD may live in the residence.

Payments by the state for EFH residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for residential habilitation does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

The provision of EFH residential habilitation (teaching and supporting) services cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, day habilitation (teaching and supporting) services, or Medicaid State Plan services. Residential habilitation (teaching and supporting) services will not duplicate other services provided through this waiver. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	employee or subcontracted provider of a certified CBDD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Extended Family Home Residential Habilitation

Provider Category:
Agency
Provider Type:
employee or subcontracted provider of a certified CBDD provider agency
Provider Qualifications
License *(specify)*:
No license is required.
Certificate *(specify)*:
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify)*:
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Habilitative Child Care

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Habilitative child care is child care provided for less than 12 hours per day and may be provided in the child's natural home or in a setting approved, registered, or licensed by the Nebraska Health and Human Services.

Habilitative child care is habilitative (teaching and supporting) in nature and not typical of child care provided to a child without a disability. Habilitation(teaching and supporting) is formal, planned training and supports and is a component of habilitative child care. Training and supports provided in Habilitative child care include adaptive skill development of daily living activities, such as eating, personal grooming, and cleanliness, and social and leisure skill development.

Habilitative child care is a coordinated effort of interventions and strategies by all service providers. Habilitation (teaching and supporting) provided by the habilitative child care provider will be documented in the IFSP, be coordinated with the habilitation (teaching and supporting) provided by the habilitation services provider, and monitored by the state DD service coordinator. The strategies and interventions utilized by the habilitative child care provider, such as positive behavioral supports, safety interventions, feeding techniques, etc. are not done in isolation or contrary to those utilized by the habilitation service provider or the educational provider. The habilitative child care provider must have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs.

Habilitative child care is available to children that live in their family home. This service may be prior authorized when both parents/guardians are working at the same time. This service does not include the cost of routine child care for the care and supervision of the client, normally provided by parents/guardians in their own home.

Habilitative child care cannot be delivered at the same time as the delivery of Community Living and Day Supports, In-Home Residential Habilitation services, Day Habilitation services, Workstation Habilitation services, Vocational Planning Habilitation services, Integrated Community Employment services, or Respite services.

Habilitative child care is not available to individuals receiving Group Home residential habilitation services, Companion Home Residential Habilitation services, and Extended Family Home Residential Habilitation services,

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Habilitative child care cannot be provided by the usual caregiver. The term "usual caregiver" means a person(s) who resides with the child, is not paid to provide services, and is responsible for the care and supervision of the child on a 24-hour basis.

Habilitative child care is available only to children residing in their family home.

Payment for habilitative child care does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

Habilitative child care cannot be provided by members of the individual's immediate household.

Habilitative child care cannot be provided by the legal guardian.

Habilitation and child care needs will be addressed in this service as specified in the IFSP.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Waiver services will not be furnished to a child while s/he is an inpatient of a hospital, nursing facility, or ICF/DD. Room and board is not included as a cost that is reimbursed under the children's waiver.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	independent agency provider
Individual	independent provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Habilitative Child Care

Provider Category:
Agency
Provider Type:
independent agency provider
Provider Qualifications
License *(specify):*
Qualified providers must meet applicable State licensure requirements as described in Nebraska Revised Statutes, Sections 71-1908 through 1918 and 391 NAC 2-000.
Certificate *(specify):*
Independent providers must be certified by DHHS in accordance with applicable state laws and regulations.
A qualified independent provider must meet certification standards, as described in state statutes and regulations.

Nebraska Revised Statutes, Sections 71-1908 through 1918
391 NAC 2-000
474 NAC chapters 5 and 6
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 10-000:

A provider of habilitative child care services must:

1. Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the child and family requests a younger provider, DHHS staff may authorize a provider no younger than age 18, considering the following:
a. The functioning level of the child;
b. The availability of back-up assistance; and
c. The capacity of the provider to meet the child's needs in the case of an emergency; and
d. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.
2. If outside of the individual's home, provide care at a site licensed, certified, or approved by DHHS;
3. Meet child care provider standards as specified in state regulations;
4. Not be a member of the individual's immediate household;
5. Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
6. Not be the usual non-paid caregiver or legally responsible relative;
7. Not be the guardian;
8. Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner;
9. Have knowledge of basic first aid skills and of emergency responses;
10. Be authorized to work in the United States; and
11. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
a) Assume responsibility;
b) Follow emergency procedures;
c) Maintain schedules; and
d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Health and Human Services agency staff
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Habilitative Child Care

Provider Category:
Individual
Provider Type:
independent provider
Provider Qualifications
License *(specify):*
Qualified providers must meet applicable State licensure requirements as described in Nebraska Revised Statutes, Sections 71-1908 through 1918 and title 391 NAC.
Certificate *(specify):*
Independent providers must be certified by DHHS in accordance with applicable state laws and regulations.
A qualified independent provider must meet certification standards, as described in state statutes and regulations.
474 NAC chapters 5 and 6
Nebraska Revised Statutes, Sections 71-1908 through 1918
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 10-000:

A provider of habilitative child care services must:

1. Be 19 years old or older. If no provider age 19 or older is available and acceptable to the family, and the child and family requests a younger provider, DHHS staff may authorize a provider no younger than age 18, considering the following:
a. The functioning level of the child;
b. The availability of back-up assistance; and
c. The capacity of the provider to meet the child's needs in the case of an emergency; and
d. If s/he is less than 19 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.
2. If outside of the individual's home, provide care at a site licensed, certified, or approved by DHHS;
3. Meet child care provider standards as specified in state regulations;
4. Not be a member of the individual's immediate household;
5. Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
6. Not be the usual non-paid caregiver or legally responsible relative;
7. Not be the guardian;
8. Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner;
9. Have knowledge of basic first aid skills and of emergency responses;
10. Be authorized to work in the United States; and
11. Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

All providers of waiver services who have direct contact with the individual receiving services must:
1. Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
2. Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
3. Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;

4. Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
5. Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
6. Exhibit the capacity to:
a) Assume responsibility;
b) Follow emergency procedures;
c) Maintain schedules; and
d) Adapt to new situations.
7. Protect the confidentiality of the individual's and family's information;
8. Accept responsibility for the individual's safety and/or property;
9. Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
10. Continue to meet all applicable service-specific standards; and
11. Operate a drug-free workplace.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Human Services agency staff

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Home modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:
Home Modifications are those physical adaptations, or structural changes to the individual's home that are necessary to ensure the health, welfare, and safety of the individual, and/or which enable the individual to function with greater independence in the home.

Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

1. Approvable modifications are limited to those necessary to maintain the individual in their own participant-directed home (not provider operated or controlled) or in the family's home, if living with his/her family.

2. Approvable modifications do not include adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual.

3. DDD will not approve home modifications if the adaptations are available under the Medicaid State Plan or from a third party source.

4. The home must not present a health and safety risk to the individual other than that corrected by the approved home modifications.

5. If the individual resides in a rental unit, the individual or family/guardian must obtain written assurance from the landlord that the property will be made available to an individual with a disability for a period of at least three years after the funding of approved home modifications, by listing the property for rent on www.housing.ne.gov.

6. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Home modifications are available only to individuals residing in their family home or a companion home.

Total cost of home modifications per participant per waiver year will not exceed $5,000.00. Unused funds do not carry over into the next waiver year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent living center
Agency	vocational rehabilitation agency
Individual	independent provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home modifications

Provider Category:
Agency
Provider Type:
Independent living center
Provider Qualifications
License *(specify):*
Licensure is not required.
Certificate *(specify):*
Certification is not required.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

The provider must meet applicable standards as described in 404 Nebraska Administrative Code 9-000 Non-Specialized Services, and 10-000 Children's Waiver Family Services.

In addition, a provider of this service must not be the guardian.

Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;

Ensure all products and materials installed shall conform to specifications. No "blemished," "seconds," or reused building materials shall be used unless otherwise noted in the quote and approved before installation;

Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;

Warrant all work, new materials, and new products for a minimum of one year;

Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility; and

Be authorized to work in the United States.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff verifies the qualifications of independent living center agency. Independent Living Center verifies the subcontracted provider.
Frequency of Verification:
Annually or per occurrence.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home modifications

Provider Category:
Agency
Provider Type:
vocational rehabilitation agency
Provider Qualifications
License *(specify):*
Licensure is not a requirement.
Certificate *(specify):*
Certification is not a requirement.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

The provider must meet applicable standards as described in 404 Nebraska Administrative Code 9-000 Non-Specialized Services, and 10-000 Children's Waiver Family Services.

In addition, a provider of this service must not be the guardian.

the provider must:

Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;

Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;

Ensure all products and materials installed shall conform to specifications. No "blemished," "seconds," or reused building materials shall be used unless otherwise noted in the quote and approved before installation;

Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;

Warrant all work, new materials, and new products for a minimum of one year;

Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility; and

Be authorized to work in the United States.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff verifies the qualifications of vocational rehabilitation agency. Vocational Rehabilitation verifies the subcontracted provider.
Frequency of Verification:
Annually for the vocational rehabilitation agency. Per occurrence for the subcontracted provider.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home modifications

Provider Category:
Individual
Provider Type:
independent provider
Provider Qualifications
License *(specify):*
All individual providers of home modifications performing electrical or plumbing work must meet applicable local and state licensure requirements and maintain current licensure.
Neb. Rev. § 71-4603
Neb. Rev. § 81-2101 through 81-2141
Certificate *(specify):*
Certification is not a requirement.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

The provider must meet applicable standards as described in 404 Nebraska Administrative Code 9-000 Non-Specialized Services, and 10-000 Children's Waiver Family Services.

In addition, a provider of this service must not be the guardian.

Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;

Ensure all products and materials installed shall conform to specifications. No "blemished," "seconds," or reused building materials shall be used unless otherwise noted in the quote and approved before installation;

Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;

Warrant all work, new materials, and new products for a minimum of one year;

Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility; and

Be authorized to work in the United States.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff
Frequency of Verification:
Annually or per occurrence

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
In-Home Residential Habilitation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Residential habilitation (teaching and supporting) services provided to a participant living in his/her family home are called in-home residential habilitation (teaching and supporting) services and are intermittent services. Intermittent services imply that community based DD provider staff support is provided when the services and supports are needed and are delivered face-to-face intermittently available to deliver habilitation (teaching and supporting) to the person receiving services in the family home or in the community.

In-home residential habilitation (teaching and supporting) services are formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Training and supports are designed to provide the individual with face to face habilitation (teaching and supporting). Training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, laundry, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. This service may also include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present.

Intermittent in home residential services are delivered in accordance with the needs and preferences of the individual, and as outlined in the service plan. There are only hourly rates for this services and an hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

Transportation between the participant's place of residence and other service sites and places in the community is provided as a component of in-home residential habilitation (teaching and supporting) services and the cost of this transportation is included in the rate paid to providers of residential habilitation (teaching and supporting) services. The time when an individual is

transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed.

The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix I-5.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Payments for residential habilitation (teaching and supporting) services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for In-home residential habilitation (teaching and supporting) services does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The amount of authorized services is individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

The provision of in-home residential habilitation (teaching and supporting) services cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, day habilitation (teaching and supporting) services, or Medicaid State Plan services. In-home residential habilitation (teaching and supporting) services will not duplicate other services provided through this waiver. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

To avoid duplicative billing, Homemaker services will not be prior authorized when the waiver participant is receiving in-home residential habilitation that focuses on teaching the individual homemaker components such as laundry, essential shopping, meal preparation, general house cleaning, or home maintenance activities.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In-Home Residential Habilitation

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify)*:
Licensing is not a requirement.
Certificate *(specify)*:
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, and 5-000 Individual Support Options.

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify)*:
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Medical Risk services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Medical risk services are provided to individuals with complex medical needs that require continuing care and treatment but are not assessed to need continuous nursing facility level of care. Complex medical needs may result from the diagnoses of some types of diabetes or seizures or may result from use of g-tubes, g-buttons, j-tubes, tracheotomies, ventilators, or a combination of the above. Treatment or interventions to meet complex medical needs require ongoing clinical assessment, professional judgment, and treatment based on ongoing assessment and cannot be delegated to unlicensed direct support professionals. The unlicensed direct support professional is an employee of the provider and meets provider qualifications.

Registered Nurses or Licensed Medical Practitioners may perform complex medical interventions. This service will be designed for those needing periodic/continual monitoring or treatment that may include medication or therapeutic services as prescribed by the individual's personal physician.

Medical risk services may also address degenerative/regressive conditions that require continuing care and treatment, and significantly impedes independent completion of activities of daily living, and impedes self-directing others to perform activities of daily living. Degenerative or regressive conditions that affect all areas of daily living activities may include cerebral palsy, muscular dystrophy, multiple sclerosis, Parkinson's disease, Huntington's disease, or other neurological impairments.

The need for medical risk services will be determined by designated staff at DDD central office. A referral is completed by the individual's IFSP team to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of DDD central office. When the team, which may include the individual's physician, believes that the individual's needs require medical risk services, the individual may be referred to DD central office for additional health assessments.

Medical risk services are provided 24/7, considered to be continuous services, and include residential and day habilitation (teaching and supporting), health maintenance activities, routine complex medical treatments, ongoing health and safety supervision, and ongoing supports. Physical nutritional management plans must be implemented as applicable. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Medical risk services may take place in a group home, extended family home, companion home, day habilitation setting, workstation, or in the community during a typical work day.

The residential habilitation (teaching and supporting) component is formalized training and staff supports for the acquisition, retention, or improvement in skills related to living in the community. Formalized training and staff supports include adaptive skill development of daily living activities, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, community inclusion, transportation, and the social and leisure skill development necessary to enable the individual to live in the most integrated setting appropriate to his/her needs. Residential habilitation (teaching and supporting) also includes personal care and protective oversight when applicable as well as supervision.

The day habilitation (teaching and supporting) service component, is provided away from the home unless prescribed to be medically necessary by the individual's physician and approved by DDD central office, and is provided during typical working hours to increase the person's independence, integration, inclusion, personal accomplishment, and employment objectives, as applicable. The habilitation (teaching and supporting) services are formalized training and supports, which focus on enabling the individual to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies in the IPP. The habilitative training and supports may include workplace training, increasing socialization and recreational skills and abilities in the community, and skills to assist in access to and integration in their community. The day habilitation (teaching and supporting) component also includes personal care and protective oversight when applicable as well as supervision.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are not an exclusive component of medical risk services and are provided when identified as a need and documented in the service plan.

Assistance with personal needs may include toileting, transfer and ambulation, skin care, bathing, dressing, grooming, meal preparation, eating, extension of therapies and exercise, and routine care of adaptive equipment primarily involving cleaning as needed.

Treatments or interventions to meet complex medical needs or address degenerative conditions are outlined in a nursing plan and included in the person's service plan. Health and safety factors including the type and amount of supervision, environmental conditions, weather conditions, architectural conditions, special diets, and safe evacuation plans are included in the service plan as applicable to the individual.

Medical risk providers must have a sufficient number of Registered Nurses on staff or under contract to develop nursing plans, provide complex medical treatments, train unlicensed direct support professionals, and oversee delegation of health maintenance activities to the extent permitted under applicable state laws.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Medical risk services are not participant directed. The amount of authorized services for medical risk services may not be determined using the objective assessment process. The rate for Medical Risk services includes a 'difficulty of care' factor such as additional compensation for Registered Nurses to complete complex medical interventions.

Complex medical treatments require ongoing assessment, professional judgment, and treatment based on ongoing assessment and can only be delegated to unlicensed direct support professionals to the extent permitted under Neb. Rev. Statute § 38-2218-2219.

Payments for medical risk services are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for medical risk services does not include DDD payments made, directly or indirectly, to members of the individual's immediate family. Immediate family is defined as a parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted) of the waiver participant. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

The provision of medical risk services cannot overlap with or supplant other state or federally funded services such as, but not limited to respite services, Vocational Rehabilitation services, or Medicaid State Plan services. Medical risk services will not duplicate other services provided through this waiver. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services. Medical risk services are all-inclusive, meaning that an individual cannot receive these services in combination with another DD waiver service.

Homemaker services cannot be authorized when an individual receives Medical Risk services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD agency provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medical Risk services

Provider Category:
Agency
Provider Type:
certified CBDD agency provider
Provider Qualifications
License *(specify):*
Registered Nurses that provide a complex medical treatment or intervention or that delegate non-complex treatments to direct support staff must be licensed in accordance with applicable state laws and regulations. 172 NAC 97-000 Neb. Rev. § 38-2201
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Team Behavioral Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Team behavioral consultation is on-site consultation by highly specialized teams with behavioral and psychological expertise when individuals with DD experience psychological, behavioral, or emotional instability which has been resistant to other standard specialized habilitative interventions and strategies that have been attempted by the certified DD provider of specialized services through the IFSP team process. Sometimes in rural areas of the state, community resources, such as psychologists or psychiatrists are not readily available to consult with or participate in meetings, or have very little experience with treating individuals with DD. Team behavioral consultation service may be requested by the IFSP team or directed by DDD central office and the need for the service is reflected in the IFSP.

Team behavioral consultation (TBC) service includes reviewing referral information, an entrance conference, on-site observations, interviews, assessments, training to direct support staff, identification of the need for referral(s) to other services if applicable, an exit conference, report of findings and recommendations, and follow-up.

The service begins with submission of a referral to DDD central office to log and forward to the assigned TBC team. The TBC team contacts the individual's service coordinator (SC) to schedule a consultation visit and the SC submits informational packet to the TBC team for review prior to the scheduled visit.

The on-site consultation begins with an initial meeting of the IFSP team – the individual, legal representative and/or parent, service coordinator, staff from habilitation service components delivered to the person (day services, residential services, or both day and residential services), other professionals serving the person in the community, as well as TBC service staff.

The TBC service is provided by a team, under the oversight of a Licensed Clinical Psychologist, consisting of a licensed mental health practitioner and two Bachelor's degree implementation specialists. The implementation specialist is an employee of the provider and meets provider qualifications. The team's work is designed to further explore the negative behavior and plan the schedule for the on-site consultation.

The TBC provider utilizes Evidence Based Treatments consistent with the presenting problems and assures the integration of physical health treatment associated with the individual referred

by TBC. This work includes completion of a bio psycho-social and functional assessment to assess the individual in their living and working environment. A Behavioral Functional Assessment is completed and data collected to determine the function of the behavior(s), an Intervention Plan will be written and then piloted, data will be analyzed to determine the final Intervention Plan. A Final Report will be constructed and include a functional analysis, triggers, intervention techniques and plans, and informal and formal supports within the individual's environment. The approach is multi-disciplinary in nature---information may be collected from all individuals involved in the individual's life including school, work, community, peers, family, mental health providers, medical professionals, and self. Training can be delivered to the IFSP team as applicable and requested, such as best practices in intervention strategies, medical and psychological conditions, or environmental impact to service delivery.

Findings and recommendations are written and discussed with the team at the exit conference and a copy is provided to DDD central office. The individual is present for the consultation.

If at any time the TBC team identifies a need for a referral as a result of the review of the individual case file, observations, interviews, and/or completion of assessments, the TBC will notify the individual's DDD service coordinator to recommend/direct that a referral be made for needs such as, but not limited to a medication review, dental work, medical evaluation, or a physical nutritional evaluation. Such referral recommendations are documented in the TBC report.

Follow-up begins after the TBC team has left the community site. The team follows up with the individual/family/provider to evaluate the implementation of the intervention and the impact that the plan has had on the individual's behaviors. Data will be collected by staff on positive and negative behaviors and also on the fidelity of the Intervention Plan. Adjustments and changes will be made to the intervention as deemed necessary by the data collected.
The recommendations from the TBC service provider for addressing behaviors and intervention strategies must be addressed by the individual's IFSP team and changes resulting from the recommendations are documented in the IFSP.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Team behavioral consultation is only available to individuals receiving services from a certified DD agency provider.

TBC will not be available to individuals that receive behavioral risk services, retirement services or only non-specialized services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

TBC services will not be furnished to an individual while s/he is an inpatient of a hospital, nursing facility, or ICF. Room and board is not included as a cost that is reimbursed under this service.

To avoid overlap or duplication of service, team behavioral consultation services are limited to those services not already covered under the Medicaid State Plan or which can be procured from other formal or informal resources such as IDEA or Rehab act of 1973. Furthermore, TBC services will not duplicate other services provided through this waiver.

A unit of team behavioral consultation is defined as a day.

The authorized amount of team behavioral consultation is not determined using the objective assessment process.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	community-based subcontracted agency provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Team Behavioral Consultation

Provider Category:
Agency
Provider Type:
community-based subcontracted agency provider
Provider Qualifications
License *(specify)*:
Team behavioral consultation staff that is a psychologist, medical staff, or a mental health practitioner are required to be licensed in accordance with applicable state laws and regulations.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120
172 NAC 94-000
Certificate *(specify)*:
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify)*:
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner;
Not be the legal guardian;
Have inpatient hospital or ICF beds available for use as needed;
Have experience offering team behavioral consultation;
Not provide TBC in cases where the provider or subcontracted provider is also the habilitation provider of the individual receiving TBC; and
Have on staff or under contract a psychologist, medical staff, mental health practitioner, behavioral specialist, and other professionals as needed.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS staff
Frequency of Verification:
As applicable, every one or two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vocational Planning habilitation service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope)*:

Vocational planning habilitation services focus on assisting the individual to attain work and are designed for individuals transitioning from youth to adulthood. Vocational Planning habilitation (teaching and supporting) services focus on enabling the individual to attain work experience through career planning, job searching, and paid and unpaid work experience with the goal or outcome of Vocational Planning being integrated community employment. Services are furnished as specified in the service plan and are delivered intermittently. Intermittent services imply that staff support is provided when the services and supports are needed. Vocational Planning services can only be billed in half, quarter, or full hour increments. An hour of service equates to one clock hour.

Vocational Planning habilitation (teaching and supporting) services are formalized training and staff supports which take place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting not owned or controlled by a DD provider, where individuals without disabilities work or meet together. Discreet habilitation (teaching and supporting) during typical working hours is allowed in preparation for leaving the place where the person lives. Direct training or teaching and supports will be designed to provide the individual with face to face instruction necessary to learn work-related responsibilities, work skills, and appropriate work behavior.

Vocational Planning habilitation (teaching and supporting) services focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion and personal accomplishment in the working community. Habilitation (teaching and supporting) may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives. Vocational Planning habilitation (teaching and supporting) services also includes the provision of personal care and protective oversight and supervision when applicable to the individual. The teaching, activities, services, supports, and strategies are documented in the service plan and delivered based on the service plan.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Vocational Planning habilitation (teaching and supporting) services may include career planning that is person-centered and team supported to address the individual's particular needs to prepare for, obtain, maintain or advance employment. Habilitation (teaching and supporting) services with focus on career planning includes development of self-awareness and assessment of skills, abilities, and needs for self-identifying career goals and direction, including resume or business plan development for customized home businesses. Assessment of skills, abilities, and needs is a person-centered team responsibility that engages all team members to support an individual in identifying a career direction and developing a plan for achieving integrated community employment at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The documented outcome is the stated career goals and career direction and strategies for the acquisition of skills and abilities needed for work experience in preparation for integrated community employment. Establishment of career goals may not take place at the same time as other Vocational Planning activities.

Habilitation (teaching and supporting) services with focus on career planning and strategies for implementing career goals may involve assisting the individual in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

Vocational Planning habilitation (teaching and supporting) services may include job searching designed to assist the individual, or on behalf of the individual, to locate a job or development of a work experience on behalf of the individual. Job searching may take place in the individual's residence, in integrated community settings, or in provider staff office areas. Job searching may not take place in a fixed-site facility in the areas where other individuals are receiving continuous day habilitation (teaching and supporting) services. Job searching with the individual will be provided on a one to one basis to achieve the outcome of this service.

Vocational Planning habilitation (teaching and supporting) services may include work experiences that are paid or unpaid, such as volunteering, apprenticing, interning, job shadowing, etc. A work experience takes place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, with the focus on attaining the outcome of integrated community employment. Habilitation (teaching and supporting) provided during a work experience may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

Prior to learning to access transportation independently, transportation may be provided between the individual's place of residence and the vocational planning habilitation (teaching and supporting) services or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services.

Vocational Planning habilitation (teaching and supporting) services may take place in conjunction with Integrated Community Employment services, Workstation habilitation (teaching and supporting) services, Day Habilitation service, or other day activities but may not be billed at the same time during a given day.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Additional staffing may be required when the youth reside in a group home or extended family home residential habilitation service settings and is not receiving educational services.

Some components of Vocational Planning habilitation (teaching and supporting) services are time-limited. Unpaid work experiences must lead to paid employment and are therefore time-limited. Work experiences for which the general population is paid to perform may not last beyond six months. Volunteering to provide services and supports in an integrated community setting for which the general population does not get paid to perform are not considered to be a work experience and are not time-limited. No more than three individuals may participate in the same paid or unpaid work experience at the same time.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified CBDD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vocational Planning habilitation service

Provider Category:
Agency
Provider Type:
certified CBDD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, and 5-000 Individual Support Options.

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the IFSP, nursing plan of care, or the individual's medical practitioner; and
Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Workstation habilitation services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Workstation habilitation services under this waiver are designed for individuals transitioning from youth to adulthood. Workstation habilitation (teaching and supporting) services are formalized training and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, community living, and employment. Workstation habilitation (teaching and supporting) services take place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting where individuals without disabilities work or meet together. Discreet training activities and supports during typical working hours is allowed in preparation for leaving the place where the person lives.

Workstation habilitation (teaching and supporting) services focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion, inclusion, and personal accomplishment in the working community. Training activities may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan. Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under

applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. The habilitative services, supports, and strategies are documented in the service plan and delivered based on the service plan.

Workstation habilitation (teaching and supporting) services are delivered continuously and provide paid work experiences in preparation for competitive employment. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Staff support is continuous, that is, staff are present at all times the individual is present. Daily rates are available for workstation habilitation (teaching and supporting) services when the person receives this service for four or more consecutive hours. Hourly rates are also available for times when the individual might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75). When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Transportation may be provided between the individual's place of residence and the workstation habilitation (teaching and supporting) services or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

DDD will not authorize developmental disabilities services for the hours the child is attending school or in a vocational rehabilitation program. Regular school hours and days apply for a child who receives home schooling.

Additional staffing may be required when the youth reside in a group home or extended family home residential habilitation service settings and is not receiving educational services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified community-based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Workstation habilitation services

Provider Category:
Agency
Provider Type:
certified community-based DD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act

471 NAC 2-000

Neb. Rev. § 83-1201 through 83-1226
Other Standard *(specify):*
The following standard is in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Service Coordination to waiver participants is provided by the Nebraska Department of Health and Human Services Division of Developmental Disabilities.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The Nebraska DHHS Central Registries are maintained by employees of DHHS. The background and criminal history checks are conducted by DHHS staff.

Nebraska regulations require that individuals must be treated with dignity and respect, be free from neglect and abuse (physical, verbal, psychological or sexual), receive appropriate medical treatment and receive services in a safe and sanitary environment.

a) Background and criminal history checks are conducted on each certified DD agency provider staff person that has direct contact with individuals served by the agency. The requirement of obtaining the background and criminal history background checks is rooted in state statute 83-1216 and state regulations governing specialized DD Services. Background and criminal history checks are conducted at the time the person is newly hired and employees who provide direct support services may not work alone with individuals served until the results of the registry checks and the criminal history background checks are reviewed by the provider.

b) The background check for certified DD agency provider staff consists of a check of the Central Registries for any substantiated reports of adult or child abuse or neglect. In addition, within ten calendar days of hire, a set of the certified agency staff person's fingerprints is forwarded to the Nebraska State Patrol to initiate the criminal history check. The Nebraska State Patrol (NSP) works in conjunction with the FBI to access information that culminates in a report of any criminal activity with which the person has ever been charged within the United States and the disposition of that case. The results of each of these types of checks are directed to the certified provider agency for their use in making hiring decisions that adhere to applicable state regulations.

In addition to these checks to ensure the appropriateness of individuals hired to provide services to vulnerable individuals, certified providers are required to comply with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

Certified and non-certified DD providers must go further than completing background checks to ensure compliance with requirements of the Adult Protective Services law for protection of vulnerable adults and children. They must also adhere to requirements of reporting even the suspicion of alleged abuse and neglect. When providers report alleged abuse and neglect to DHHS Protection and Safety Specialists (PSS) that are not required by law, the PSS shares this information with DDD within 24 hours of receipt. DDD staff reviews the information and makes a determination whether to conduct a complaint investigation or address the complaint in another manner.

c) Certification review activities conducted by DDD staff ensure that mandatory internal reviews and/or investigations have been conducted by the specialized provider agency. Certification reviews include on-site review activities, development of a written report of findings, review of any plan of correction, and review of follow-up reports submitted by the agency provider with updates on the provider's implementation of the plan of correction. Agency systems of operation are also reviewed to verify that mandatory internal reviews/investigations have been conducted, including a review of activities of quality improvement, due process for restrictive procedures and handling of complaints, review of allegations of abuse or neglect, employee background checks, and staff training. DDD staff complete review checklists and utilize the information gathered to develop a written report of findings.

a) Non-specialized independent providers who will provide direct contact services and supports, and if services will be provided in the provider's home, any member of the non-specialized provider's household undergo background and criminal history checks before approval and annually if the provider's services are renewed.
b) Sources for the background check and criminal history check include: the Nebraska DHHS Central Registries for any substantiated reports of adult or child abuse or neglect, Nebraska's on-line Sex Offender Registry, on-line Department of Justice (DOJ) records, Department of Motor Vehicle (DMV) records, and a check of local law enforcement criminal records. There must be a signed statement by the provider giving information about all felony or misdemeanor pending charges, arrests, and convictions. If additional information is needed to evaluate the criminal history of the provider or household member, DHHS will obtain a release of information from the non-certified provider or household member; and request information available from law enforcement. DHHS may deny or terminate provider approval of an applicant or provider who refuses to sign a release of information.

c) After DHHS staff completes the background checks, the staff verifies that background checks have been completed by marking the "Request for Provider Approval" form or the "Provider Background Check Results form", whichever is applicable to their job duties. The form includes verification that APS, CPS, and SO registries, DOJ records, and DMV records are checked and the date the registries were checked.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The Nebraska DHHS Central Registries are maintained by employees of DHHS. The background and criminal history checks are conducted by DHHS staff.
b) Service coordinators and all waiver providers who will provide direct contact services and supports, and any member of the non-certified independent community provider's household (if services will be provided in the independent provider's home) undergo registry screening, background and criminal history checks.
c) There must be a signed statement giving information about all felony or misdemeanor pending charges, arrests, and convictions. If additional information is needed to evaluate the criminal history of the provider or household member, DHHS will obtain a release of information from the provider or household member; and request information available from law enforcement. DHHS may deny or terminate provider approval of an applicant or provider who refuses to sign a release of information.

After DHHS staff completes the background checks, the staff verifies that background checks have been completed by marking the "Request For Provider Approval" form or the "Provider Background Check Results form", whichever is applicable to their job duties. The form includes verification that APS, CPS, and SO registries are checked and the date the registries were checked.
No contract is issued prior to completion of background and criminal history checks. See C-2-a above for additional information.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
licensed Center for persons with developmental disabilities (CDD)	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

In Nebraska, the setting in which the individual lives is considered to be the individual's home, whether it is his/her family home, a participant-directed companion home, a provider operated group home, an Extended Family Home, or a licensed Center for persons with DD (CDD) (this licensure is required for residential facilities that serve four or more individuals with DD). The facilities are single family homes and apartment complexes in residential neighborhoods and are indistinguishable from other houses, duplexes, condominiums, or townhouses. The homes have a kitchen with cooking facilities, breakfast nooks or small dining areas, living rooms, family rooms or dens, bedrooms, and single bathrooms. The person's bedroom, 'family room' or 'den' in the group home or licensed CDD allows for privacy, and visitors are welcome at times convenient to the individuals.

Individuals may decorate their personal space however they wish, and for common areas shared by more than one individual, input from each person is sought, and consideration is given to each person's needs, preferences, likes, and dislikes. The residential facilities are located in residential neighborhoods in the communities and have agency transportation or easy access to public transportation to visit friends, and participate in integrated and inclusive activities in their communities.

Two methods are utilized to monitor the home and community character - service coordination monitoring and quality review team monitoring.

Service Coordination monitoring -
DDD Service Coordination (SC) monitors the implementation of each IFSP in its entirety twice annually in addition to the ongoing monitoring of the IFSP which may involve specific areas of the IFSP within each monitoring session. Full reviews are conducted at least twice annually on each person in services with ongoing monitoring conducted between the full monitoring.

One area that is monitored is the home environment. DDD service coordination staff observe the individual in his/her home and check Yes or No for the following indicators;
• Free from obvious safety hazards (ripped carpets, mold, offensive odors, and chemicals)
• Environment has been adapted to meet the person's physical or behavioral needs
• General condition of home furnishing and/or personal belongings is in good repair (no holes in wall, broken doors/windows)
• access to a kitchen with cooking facilities and a dining area.

Quality Review Teams -
DDD has created a venue, known as Quality Review Teams (QRTs) through which families, guardians and advocates of people with developmental disabilities will interact with people served by certified DD service providers in their service environments and make recommendations to improve the quality of services. Oversight of the activities of quality review teams is a function of the DDD Central Office.

DDD contracts with an outside entity to develop and coordinate Quality Review Teams. The terms of the contract have been established to comply with the requirements of the Developmental Disabilities Services Act and ensure that activities of QRTs are available to individuals served by all certified community-based DD service providers.

The consultant coordinates the activities of the quality review teams, subcontracting with a local coordinator to establish the local team. The team members visit a person's home and observe the environment, affect of individuals served, and interactions between individuals and staff persons. Quality review team members generate a written report after every on-site visit. They rate the agency in five areas: staffing, personal growth, regard for the individual, physical setting and safety using a (+) for positive impressions and a (-) for impressions that the agency needs to make improvements. If the team members don't have strong feelings one way or the other about their impressions of a category, the category receives a rating of "N/A". The report is written in narrative form and includes observations and recommendations. If something of concern is noted, it is expected that the agency respond in writing to the local coordinator.

Quarterly, the consultant submits to DDD central office:
1. Copies of each site report and the responses to those reports received from the provider agency;
2. An authenticated listing of the team members participating in each visit and a description of the role each team member fulfilled; and
3. A summary of the activities of the QRTs and consultant during the quarter just completed.
The reports must also include conclusions drawn by the consultant based on review of the individual site reports and provider responses received during the quarter.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

licensed Center for persons with developmental disabilities (CDD)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Vocational Planning habilitation service	☐
Team Behavioral Consultation	☐
Behavioral Risk Service	☑
Workstation habilitation services	☐
In-Home Residential Habilitation	☐
Community Living and Day Supports	☐
Integrated Community Employment - Individual Employment Support	☐
Extended Family Home Residential Habilitation	☐
Companion Home Residential Habilitation	☐
Respite	☑
Day Habilitation	☐
Homemaker	☐
Group Home Residential Habilitation	☑
Home modifications	☐
Habilitative Child Care	☐
Medical Risk services	☑

Facility Capacity Limit:

Capacity is limited to 14 individuals per group home or licensed Center for persons with DD

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑

Standard	Topic Addressed
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives, other than the waiver participant's parent, spouse, or child (biological, step, or adopted) may be direct providers of non-specialized Habilitative Child Care, Homemaker, and Respite services. Relatives, other than the waiver participant's parent, spouse, or child (biological, step, or adoptive) may be indirect providers of Home Modifications. Relatives, other than the waiver participant's parent, spouse, or child (biological, step, or adopted) may be direct or indirect providers of specialized Group Home Residential Habilitation, Integrated Community Employment, Prevocational Habilitation, Behavioral Risk, Day Habilitation, Companion Home Residential Habilitation, Extended Family Home Residential Habilitation, In-Home Residential Habilitation, Medical Risk, Vocational Planning Habilitation, or Workstation Habilitation services. The State makes payment to relatives when it is determined the provider meets and maintains all standards and requirements outlined in applicable state regulations.

The provision of services by the relative is determined through documented team discussion during the planning process. The provision of services is monitored by the participant's state DDD Service Coordinator.
Determination that the above circumstances apply is determined by the participant and his/her team and verified during enrollment of the independent provider, prior to the issuing of a contract. This is determined on a case by case situation by the individual's IFSP team. In rural areas, there may not be providers who are available or who have experience in working with individuals with DD. A relative may be available and would know the needs and preferences of the child.
The State does not make payments:
1. Directly or indirectly, to relatives who are the parent, spouse, or child (biological, step, or adopted) of the individual;
2. To members of the individual's immediate household, including relatives/legal guardians;
3. To a legally responsible relative/guardian,
4. For the routine care and supervision which would be expected to be provided by a family, or
5. For activities or supervision for which a payment is made by a source other than Medicaid.

There are no additional limitations on the amount of services just because the provider is a relative.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) that are available to the individual.

The following controls are employed to ensure payments are made only for services rendered:
1. The need for the service is documented in the IFSP;
2. DHHS staff have enrolled the independent provider and prior authorized each waiver service to be delivered;
3. When provided by an independent provider, a calendar is completed, listing the date(s) of services(s), the specific task(s), and the times of service, and signed by the waiver participant or designee, verifying the services have been delivered as claimed;
4. A calendar, when applicable and claim are submitted to DHHS for approval and processing;
5. DHHS staff verify and approve the claim and submit claim to DHHS claims processing staff for processing; and
6. Edits are in place in the computer system.

- ○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Process for enrollment of certified DD agency providers is as follows:

DD service provider agencies are certified under applicable titles of the Nebraska Administrative Code. The certification process for DD agency providers is conducted by DDD staff.

Central office staff is responsible for certification and contracting of new agency providers. Central Office staff routinely field inquiries about becoming a certified agency provider of community-

based services for persons with developmental disabilities by providing verbal and written information to assist the interested party. These interactions may lead to development of a new service agency provider to increase the availability and choice of services and providers for persons with developmental disabilities.

DDD has developed a process to support central office staff in providing information to interested parties and collecting a consistent set of information to support provider development activities. Appropriate website links and documents are sent electronically to interested parties who have asked for further information. The names and other contact information of callers who have inquired or expressed an interest in becoming a specialized service provider in Nebraska are recorded on a list kept by the DDD administration. DDD administration further communicates with interested parties as needed through email, conference calls, and face-to-face meetings.

Requirements and procedures for becoming a certified DD service provider agency are published on the DHHS website in 404 NAC chapters 4, 5, and 6. Prospective providers may also contact DD central office by phone, letter, or e-mail and the prospective provider will be contacted.

As potential providers submit the required application, with policy and procedure manuals, the provider is assigned to a state DDD staff member for review of submitted information initiating the process for certification by DDD as a specialized provider. The assigned DDD staff person reviews information as it is submitted, and provides feedback, requests information, and specifies timelines throughout the certification work. When all the necessary qualifications are met the potential provider is informed that their agency has met DD provider agency certification requirements.

The following is the process for enrollment of independent providers:

Following the development of the IFSP, the individual, legal representative, and family, as appropriate, will work with the state SC and other designated DHHS staff to locate and select independent providers to deliver the services.

Information for becoming an independent provider can be obtained from the waiver participant, his/her advocate, his/her legal guardian, or DHHS staff (resource development staff, his/her SC, or his/her Social Services Worker).

Individuals have the option of finding qualified individuals or agencies that are interested in providing non-specialized waiver services. Individuals often draw from their personal networks of family members not living in the household and who are not legally responsible, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students. Individuals utilize the internet as a resource for potential providers. Answers4Families is an internet family information and resource center, developed by DHHS in partnership with the University of Nebraska Center on Children, Families, and the Law. E-mail discussion groups are available and the directory (Nebraska Resource and Referral System) includes over 8,000 providers of services and supports in the state. Ready, Set, Go! is a web-based series of materials and resources intended to assist in making decisions about supports for young adults with intellectual or developmental disabilities as they move for high school to adult life.

DHHS staff also makes available to the individuals an extensive list of current service providers enrolled under other DHHS programs, such as chore, child care, respite, HCBS waiver for Aged and Disabled, HCBS waivers for adults with DD, personal assistance services, etc. Individuals interview the potential provider to determine whether the amount of experience, knowledge, and education or training will meet the consumer's needs. The potential provider is referred to DHHS staff for enrollment. All willing and qualified providers can enroll.

DHHS staff are responsible for enrolling independent individual or agency providers as waiver providers. Upon receipt of a referral, DHHS staff responsible for enrolling an independent provider contacts the potential provider to schedule a meeting at the provider's convenience. Following the enrollment meeting, DHHS staff immediately completes the enrollment process and issue a contract to the provider.

There is no timeline for enrollment of independent providers. It is based on the immediacy of the need for the services by the provider. When a provider is needed immediately, to the best of the State's and provider's ability, the provider is enrolled immediately. Some providers are enrolled as back-up providers and the scheduling of the appointment may be delayed. Timelines for DHHS staff are determined by local DHHS administrators. Generally, enrollment is completed within 1 day to 4 weeks of initial contact.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of certification/compliance reviews completed on certified provider agencies, the number of providers cited for failure to adhere to required regulations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the state DDD QI committee

Performance Measure:
Of the total number of newly certified providers, the number of providers that initially meet required background checks prior to delivery of waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the state DDD QI committee

Performance Measure:
Of the total number of certified providers, the number of providers that continue to meet all required certification standards and applicable licensure requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: semi-annually	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS report of licensed Centers for Persons with DD

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the state DDD QI committee

Performance Measure:
Of the total number of DD provider agencies reviewed initially, the number of providers that initially meet required certification standards and applicable licensure requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS report of licensed Centers for Persons with DD

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Out of the total number of providers that are monitored, the number of providers that are managing services and supports as documented in the individual's service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordination Monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the DD QI committee

Performance Measure:
Out of the total number of background checks completed on non-licensed/non-certified providers, the number of background checks completed prior to provider approval.

Data Source (Select one):
Other
If 'Other' is selected, specify:
The Request for Service Provider Approval form or the Provider Background Results form

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: As determined by the state DDD QI committee

Performance Measure:
Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that met initial waiver provider qualifications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
service authorizations

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the DDD QI committee

Performance Measure:
Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that continue to meet waiver provider qualifications.

Data Source (Select one):
Other
If 'Other' is selected, specify:
service authorizations

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	semi-annually or as determined by the DDD QI committee

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of certification/compliance reviews completed on certified provider agencies, the number of provider agencies that have met training requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the state DDD QI committee

Performance Measure:
Out of the total number of waiver participants, the number of individuals that had no issues with their non-licensed/non-certified independent provider performance.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordination Monitoring database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the DDD QI committee

Performance Measure:
Of the total number of certified provider agencies that employ staff, the number of agencies that have training records for their employees that indicate these staff have met provider training requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Summary of On-Site Certification Activities

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the DDD QI committee

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Monitoring for compliance with the above sub-assurances is completed at the local level by the DDD SC and at the central office level by DDD Surveyors and management staff.

An established DD Quality Improvement Committee meets quarterly and reviews reports on a variety of QI activities on a rotating, scheduled basis. The state QI committee reviews the data for the certification activities and the monitoring data semi-annually. Recommendations are made for action by appropriate parties, including DDD management, members of the committee, and other DHHS staff. Appropriate reports are communicated by DDD management during monthly or quarterly meetings with provider organizations, the DDD Advisory Committee, the Nebraska DD Council, DD surveyors, Service Coordination staff, and other interested parties.

Non-specialized services are services directed by the individual or family, or guardian when the youth is a minor, and delivered usually by independent providers. Specialized services are traditional habilitation services that provide residential and day habilitative training and are delivered by certified DD agency providers.

Each specialized DD provider agency is certified by DDD. DDD certifies providers in accordance with state regulations on an annual or biennial basis; depending on the results of the

certification review (significant issues can lead to shorter certifications or termination of contracts to provider services). As a part of the certification process, checks are made to ensure providers are conducting services in accordance with regulations, including ensuring training is occurring as specified in regulations and their policies and procedures, that they have a functional QI or QA systems and that they have a functional complaint mechanism.

Aggregate reports of the on-site certification activities conducted by the certification teams comprised of the Division's DD Surveyors are reviewed semi-annually by the QI Committee. The on-site certification summary includes the number of certifications conducted and the frequency of compliance issues cited by type.

DDD contracts with certified DD provider agencies for services under this HCBS waiver. Certified providers are responsible for furnishing training to their employees. DHHS enters into a provider agreement/contract with non-certified independent providers.

Independent providers, which can be individuals or agencies, provide non-specialized services. DDD does not require licensure or certification for providers of non-specialized waiver services. All providers of waiver services must be Medicaid providers as described in the Title 471 regulations. Failure to meet the regulatory requirements may result in termination or suspension of the provider agreement. Signing the provider agreement does not mean the provider is an employee of DHHS.

Non-specialized waiver providers must meet the standards outlined in the approved waiver and in the state regulations. In addition to the general standards and conditions for all non-specialized waiver providers, there are specific standards that persons who provide particular types of waiver services must meet whether operating independently or through an agency.

Once DHHS approves the non-specialized provider (contract and authorizations in place), the family trains the provider based on the service that will be provided and the specific needs of the individual and family. A consumer handbook is provided to each waiver participant which includes information on the purpose and use of the handbook; an introduction to non-specialized services; rights, responsibilities, and risks; developing a plan; finding providers; hiring providers; training providers; working with providers; personal safety; and monitoring the plan.

Waiver recipients and/or their families also receive a provider handbook so that they know, when training and directing their providers, what standards and qualifications providers are expected to meet. The provider handbook includes an introduction, respecting the individuals and families, general standards, standards for specific services, and information on authorization and billing.

Providers may receive information about becoming a provider from the waiver participant, his/her family, his/her advocate, his/her legal guardian, or DHHS staff (resource development staff, his/her Service Coordinator, and/or his/her Social Services Worker). The potential provider is referred to the appropriate DHHS staff for enrollment. All willing and qualified providers may enroll.

Once enrolled, each independent provider of participant directed services is trained and directed by the waiver participant and/or their families.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When an issue with performance of an independent provider is identified, a plan to address the issue is discussed and documented. The individual and/or their representative may directly address the provider or may ask their SC to assist in addressing the concerns or issues with the provider. The SC will follow through with the individual and/or their representative or on behalf of the individual until the issue is resolved.

The SC is responsible for facilitation and development of the IFSP, and then monitoring the implementation of each IFSP in its entirety twice annually in addition to the ongoing monitoring of the IFSP which may involve specific areas of the IFSP within each monitoring session.

Waiver participants may ask for assistance from their SC in communicating to their independent providers the expectations, compliments, areas that need improvement, concerns, unacceptable practices, etc. The SC may increase monitoring activities, participate in discussions with the participant and provider, suggest topics for the individual to discuss with the provider, facilitate revisions to the IFSP, or, upon direction from the individual and/or their representative, terminate the authorizations for that provider.

Service coordination supervisors conduct quality assurance reviews of one hundred per cent of IFSPs and record additional evidence of the IFSP process to ensure the IFSP reflects the individual's directions, preferences, and personal and career goals, and is based on adequate assessments of their abilities. When variances are noted, the SC Supervisor oversees the action taken by the Service Coordinator to correct the IFSP.

DDD Service Coordination monitors the implementation of the IFSP to ensure the timely and efficacious delivery of all services specified in the IFSP for the person. Full reviews are conducted within 60 days of the annual and semi-annual IFSPs. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the consumer, their family, or others. Additional monitoring tools specific to behavioral, medical, or nutritional needs of a particular individual are utilized on a schedule determined by the IFSP team or DDD central office. The full reviews consist of checking on 49 items grouped into seven groupings – rights, habilitation, financial, service needs, health and safety, home/work environment, and individual's input which utilizes the core questions from the Personal Experience Survey. Examples of what the SC monitors and responds to are whether the services documented in the IFSP are authorized and provided; whether management of services, supports, and providers is occurring as documented, whether provider schedule generally follows the preference of the individual/legal representative, whether the individual and/or legal representative are satisfied with the support of the independent providers. If utilized, the effectiveness of back up plans for the provision of services is also monitored.

Monitoring information is documented and entered into a database or spreadsheet. This information is summarized and reviewed by the QI Committee quarterly. The summarized data for the IFSP review is also shared with Service Coordination District Administrators.

By statute, certified providers are required to report as Mandatory Reporters any suspected incidents of abuse/neglect to DHHS adult/child protection and safety staff (APS/CPS). DD Central Office is notified electronically by APS/CPS of reports made involving individuals in DD services, and these reports are searched and monitored on a daily basis by Central Office staff (M-F). In addition, Service Coordinators receive an electronic "alert" or APS/CPS reports on individuals on their caseload. These reports may result in increased monitoring by service coordination, a certification or contract compliance review, technical assistance, or some other type of remediation and follow-up activities.

In addition, certified providers are required to report incidents that are categorized as "High" or "Medium" to Central Office and Service Coordination immediately following the incident with submission of the incident report within 24 hours. "High" reportable incidents include:
Allegation of abuse, neglect, or exploitation
Injuries with severity level of Severe (Hospital, ER/admission)
Injuries with severity level of Death
Injuries with cause undetermined
Deaths of persons served
Law enforcement involvement initiated by staff persons employed by the provider or by people in the community who report concerns about the provider's services
Fire attempted/caused by individual
Hospitalizations (Admission or ER w/o admission)
Suicide attempts/threats
Use of chemical, physical, or mechanical restraint
Unplanned Emergency Safety Intervention

"Medium" reportable incidents include:
An individual served leaving staff supervision where the safety of the individual or others is potentially threatened. (AWOL/Missing Person). If Police are contacted, an additional event should be added to the report.
Injuries with severity level of Moderate (Nurse/Physician treatment)
Possible Criminal Activity/Misconduct
Use of Emergency Safety Intervention included in the Safety Plan

The incidents are reported by certified providers using a state-sponsored online system. DDD staff review these daily and follow-up on significant issues. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on an individual and provider wide level to address the issue and to decrease the likelihood of future incidents. The online system generates aggregated reports of all incidents and the QI committee reviews aggregate data stratifying by type of incident and provider.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually and/or as determined by the DDD QI coordinator

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

a) The total amount of home modifications cannot exceed $5000.00 per the individual's waiver year.

b) Based on analysis of data from other DHHS programs, research of other states that offer similar services and supports, and current data, the limits have been sufficient to assure the health and welfare of the waiver participants. The expenditures and utilization are tracked and the IFSP is reviewed, at a minimum, semi-annually.

c) The state may adjust the limits during the period the waiver is in effect. The limits will be adjusted to take into account cost increases and will be periodically re-evaluated in light of changes in utilization patterns or other factors. The State will submit a waiver amendment to CMS to adjust the dollar amount.

d) When health and welfare needs cannot be met within the limits, adjustments, exceptions, or a referral to another HCBS waiver or non-waiver services and supports will be determined on a case by case basis. An exception request that includes justification for an adjustment to the person's budget may be made to the Community Based Administrator by the DDSC.

e) The State has established the following safeguards to avoid an adverse impact on the participant - The participant is referred to another waiver that can accommodate the individual's needs, or the participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs.

f) Participants are notified in writing by DHHS staff of the limits at the time of initiation of DD services and in the development of the IFSP.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

a) The budget amount is the individually objectively assessed funding amount per the individual's waiver year and is determined by DDD staff. The total amount of home modifications cannot exceed $5,000.00 per the individual's waiver year and is not included in the individual's funding amount.

b) The determination of funding for individuals is determined using the 'Objective Assessment Process' or OAP as stated in statute and regulations. Funding is assigned based on an objective assessment of each person's abilities, to provide for equitable distribution of funding based on each person's assessed needs. This process has been used since 1999 for persons new to services or requesting an increase in their funding. An individual's funding for respite, medical risk service, and behavioral risk service is not determined using an objective assessment process.

The assessment to ascertain each person's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). State staff completes the ICAP assessment with input from the individual's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation. This assessment is submitted to the DDD Central Office where the overall score is determined. An ICAP is completed for persons new to services, when a person adds either day or residential services or when they have a significant change in supports or abilities.

Additional funding may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Based on input from the provider and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request an exception to the OAP. The amount of exception funding is determined administratively based on justification by the team of a temporary increased service need of the individual. To the base funding, determined by OAP, is added the cost of provider supports to mitigate any risks identified in clinical assessments.

The individual's service coordinator is informed of the prospective individual budget amount. The SC shares this amount with the individual and their family or legal representative only. The individual's prospective budget amount is not open for public inspection.

c) The state may adjust the limits during the period the waiver is in effect. The limit will be adjusted to take into account cost increases and will be periodically re-evaluated in light of changes in utilization patterns or other factors. The State will submit a waiver amendment to CMS to adjust the dollar amount.

d) The participant's health and welfare needs will be addressed by the team. Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports may be accessed. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case by case basis.

e) The State has established the following safeguards to avoid an adverse impact on the participant - The participant is referred to another waiver that can accommodate the individual's needs, or the participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs.

f) Participants are notified in writing by DHHS staff of the limits at the time of initiation of DD services and in the development of the IFSP.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The following services are provided in settings that are by their nature, in integrated community settings that are compliant with 42 CFR 441.301(c) (4)-(5). The quality of the experiences of the individual receiving services, occur in community settings. Individuals have the choice of providers, services, and settings, and that choice is documented in the individual's service plan. The settings are not located in a building that is publicly or privately operated facility that provides inpatient institutional treatment. The settings are not on the grounds of, or immediately adjacent to, a public institution. The settings do not have the effect of isolating individuals receiving waiver services from the broader community of individuals not receiving waiver services. These services will continue to meet HCB Setting requirements through already existing prohibitions of these services from being provided in provider-owned and controlled settings.
• In-home Residential Habilitation,
• Extended Family Home Habilitation,
• Community Living and Day Supports, and
• Integrated Community Employment.

In-Home Residential Habilitation services are provided to a participant living in his/her family home. Community based DD provider staff go to the participant's home that is shared with his/her family to deliver habilitation (teaching and supporting) services either in the home or to take the person into the greater community. The family home cannot be a provider-owned or controlled setting.

Extended family home (EFH) residential habilitation (teaching and supporting) services are services delivered in a single family home where the individual and the EFH provider live or delivered in the greater community by the EFH provider. The home is privately rented or owned by EFH provider.

Community Living and Day Supports (CLDS) is a participant-directed service that provides the necessary assistance and supports to meet the daily needs and preferences of the individual. CLDS is provided with the individual present to ensure adequate functioning in the individual's private home, as well as assisting the individual to participate in a wide range of activities outside their home. CLDS may also provide the necessary assistance and supports to meet the employment and/or day service needs of the individual in integrated community settings. CLDS includes but is not limited to supports to enable the individual to access services and opportunities available in community settings. This may include accompanying the participant to and facilitating participation in general community activities, community volunteer work, and services provided in community settings such as senior centers and adult day centers where individuals without disabilities might receive similar services. Community Living and Day Supports cannot be delivered in a provider-owned or controlled setting.

Integrated Community Employment (ICE) services are primarily provided away from the home, in a non-residential community integrated setting, during typical working hours and conducted in a variety of work settings, particularly work sites where persons without disabilities are employed. Community settings for the delivery of ICE are in neighborhoods, sub-divisions, and business districts within villages, towns, and cities where people without disabilities, live, shop, and work. ICE cannot be delivered in provider-owned or controlled settings.

In addition, these additional services are meant to enhance community integration among participants. These services are not specific to settings but rather are a type of service delivered to individuals.
• Homemaker (4154),
• Habilitative Childcare (4154)
• Team Behavioral Consultation, and
• Home Modifications.

Habilitative child care can be provided by an independent provider, child care agency, or certified DD provider agency and can be delivered in the individual's private family home, the independent provider's home, or child care center. The provider's home/facility must be architecturally designed to accommodate the needs of the individual and must be accessible to the individual. This service cannot be provided in provider-owned and controlled settings.

Homemaker services are the general household activities necessary for maintaining and operating the child's family home to allow the usual caregiver to attend to and nurture the individual. This service cannot be provided in provider-owned and controlled settings.

Team Behavioral Consultation (TBC) services are provided where the person participates in his/her community. TBC is not facility-based and the TBC team goes to the community where the individual lives and works. Observations where the individual lives, and/or takes part in day services or other activities are conducted at any time of the day or night, depending upon when and where the specific target behaviors are exhibited. IPP team members are interviewed and assessments are completed. The current interventions are noted and efficacy of those current methods are assessed. Behavioral interventions are developed, piloted, and evaluated, and revised, as necessary. Training is delivered to the IPP team as applicable and requested, such as best practices in intervention strategies, medical and psychological conditions, or environmental impact to service delivery.

Home Modifications are those physical adaptations, or structural changes to the individual's home that are necessary to ensure the health, welfare, and safety of the individual, and/or which enable the individual to function with greater independence in the home. Home Modifications are modifications limited to those necessary to maintain the individual in their own participant-directed home (not provider operated or controlled) or in the family's home, if living with his/her family. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual and Family Support Plan (IFSP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**
☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐ **Licensed physician (M.D. or D.O)**
☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

Qualifications of a DHHS DDD Service Coordinator (case manager) are as follows:

Bachelor's Degree and professional experience in: education, psychology, social work, sociology, or human services, or a related field and experience in services or programs for persons with intellectual or other developmental disabilities is preferred.

Ability to: assess the needs of persons with intellectual and other developmental disabilities; evaluate assessments; determine eligibility; develop and assess individual service plans; mobilize resources to meet individual needs; communicate effectively to exchange information; develop working relationships with indivduals with intellectual or developmental disabilities, their families, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; conduct formal assessments; monitor services provided; apply agency and program rules, policies, and procedures; and organize, and evaluate, and address program/operational data.

Knowledge of: current practices in the field of community-based services for persons with intellectual disabilities and other developmental disabilities; the role of the service coordinator; person-centered program planning; the principles of normalization; provision of habilitation services; positive behavioral supports; and statutes and regulations pertaining to delivery of services for individuals with developmental disabilities.

Knowledge of: the program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities; regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; State statutes regarding persons with disabilities; and Department programs, such as Protection and Safety and public assistance programs.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The individual's DDD service coordinator provides support to the individual (and/or family or legal representative, as appropriate) to actively lead in the service plan development. The individual and/or family or legal representative also has the option to direct his/her service coordinator to facilitate the service plan development meeting so that the person and/or family or legal representative may actively participate as a team member.

a) Information about the waiver program; the participant/family roles and responsibilities; due process rights; providers' roles and responsibilities; for applicable participant-directed service options, “how to” hire, fire, and direct providers; and claims review and verification is provided to participants and families. Information is provided verbally and in written form prior to entry into the waiver services. Information is provided to individuals and families by DDD staff at a local level as needed.

(b) Persons eligible for DD services have an IFSP developed prior to the initiation of waiver services. This person-centered and self-directed plan is individually tailored to address the unique preferences and needs of the person. Participants in the planning process will be determined by the individual and the legal representative, but must at least include the individual, representatives of specialized DD provider(s), the Service Coordinator, and the legal representative if there is one. The IFSP must identify the needs and preferences of the individual and specify how those needs will be addressed. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid resources.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) Persons eligible for waiver services have an IFSP developed prior to the initiation of services and annually thereafter. This person-centered and self-directed plan is individually tailored to address the unique preferences and needs of the person. Participants in the planning process is determined by the individual and/or the family or legal representative, if applicable, but must at least include the individual, the service coordinator, the legal representative if there is one, and DD provider agency representatives when specialized DD services are provided. The service coordinator is responsible for scheduling, coordinating, and chairing all IFSP meetings and facilitating the participation of all team members. The service coordinator elicits and records facts and information from other team members, advocates for the person receiving services, encourages team members to explore differences and discover areas of agreement so that consensus can be reached, documents the IFSP and the specific responsibilities of each team member with regard to implementation of services, supports, and/or strategies, and adheres to the electronic format for documentation of implementation of revisions to the program plan. Meetings are scheduled at a time and place that accommodates the needs of the individual served, the legal representative of the person receiving services (if applicable), the parent(s)(if the person desires parental involvement in the process), and the chosen advocate of the person receiving services (if applicable). Dates for regularly scheduled IFSP meetings are scheduled well in advance to assure attendance by all team members. The person and/or family receiving services or any other team member of the interdisciplinary team may request a team meeting at any time. Only the requestor may withdraw his/her request.

(b) The IFSP must identify the needs and preferences of the individual and specify how those needs will be addressed. Assessments to support the service plan development are determined by the team and may include, but are not limited to, the Inventory for Client and Agency Planning (ICAP), Developmental Index, assessments completed by the specialized DD provider, if applicable, assessments completed during the participant’s school years, if applicable, and the Supports Intensity Scale (SIS).

(c) The participant is informed of the services that are available under the waiver prior to the initial plan development and annually thereafter at the pre-IFSP meeting known as the individual and family meeting. Information about services is also provided on the DHHS public website and when eligibility for DD services is determined, when funding is approved, and upon request.

(d) Prior to waiver entrance, an interdisciplinary team develops a detailed annual plan. The DD Service Coordinator is responsible for coordinating waiver services. The annual plan includes, as appropriate:

Employment goals and strategies when the youth is at least 16 years of age;
Medical information;
Nutritional considerations;
As applicable, physical nutritional management plans;
Adaptive devices, including support and protective devices;
Physical and nutritional supports;
Medical conditions and known allergies;
Medications;
Rights and rights restrictions;
Legal needs;
Finances;
Identification of basic and other needs, which include:

1. Physical survival
2. Physical comfort
3. Emotional well-being/happiness and personal satisfaction

4. Personal independence and self-care
Description of strategies to meet the needs;
Requested service(s);
Description and schedule of strategies, services, and supports to be provided, taking into consideration individual's personal and career goals and identified needs;
Identified plan to locate provider(s), if applicable;
Back-up plan, for each participant-directed service, in the event non-specialized services can't be provided or aren't provided as scheduled.

The IFSP indicates how the team believes that this plan will meet the health and safety needs of the individual. These needs may be met by a combination of specialized DD services/supports, non-specialized supports, natural supports, or services/supports from other programs. If it is determined that the needs cannot be met under the current plan without posing a threat to the health and safety of the individual, the team will re-consider the appropriateness of the individual receiving services through the waiver. This may require referral to other services or programs and the development of an alternate plan.

(e) The IFSP must include identification of the prospective budget amount and the projected monthly cost/utilization of the services and supports to be provided, as well as services and supports to be provided by other non-DD funded resources. The DD Service Coordinator is responsible for coordinating waiver services.

(f) The IFSP document identifies the services and supports, schedule of delivery of services and supports, and responsibilities to implement the plan. The service coordinator is responsible for monitoring the implementation of the plan by observing and documenting observations on the IFSP monitoring form. Monitoring is completed at a minimum, within 60 days following the annual and semi-annual meetings and as opportunity arises.

(g) The IFSP document must be completed and signed by all team members at the meeting. At a minimum, the IFSP is developed annually and reviewed semi-annually, and is updated when circumstances and/or needs change.

The purpose of the annual IFSP meeting is to determine waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the individual to achieve his/her future plan, or personal goals.

The purpose of semi-annual IFSP meeting is to review the implementation of the annual IFSP, to document the individual's future plans and personal goals, to explore how the team can assist the individual to achieve those goals, to determine what information is needed to develop appropriate supports to assist the individual to achieve future plans, to assign responsibility for gathering information if needed, and to review any other issues which have impact on the individual's and/or family's life.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Assessment is required at least annually in conjunction with development of the IFSP to identify the preferences, skills and needs of the person.

Strategies are developed by the team to address areas of risk that are identified through the assessment process. If, for example, it is identified through assessment that a person has the need to have their blood pressure monitored, the team would determine the method for ensuring such monitoring and informal teaching may be provided to enable the person to develop independence in the skills necessary to self-monitor. In addition to the informal teaching, the team would develop a strategy for inclusion in the IFSP as a backup plan. The strategy specifies who will be responsible for monitoring the individual's blood pressure and how often it must be monitored.

The following is included in every IFSP:
1. A description and schedule of waiver services and supports to be provided, taking into consideration the individual's goals, preferences and identified needs;
2. The identified provider(s);
3. A back-up plan for each non-specialized service, in the event non-specialized services can't be provided or aren't provided as scheduled. Back-up plans may include a temporary increase in natural supports, hiring additional on-call providers, etc.;
4. Documentation of how the team believes that this plan will meet the health and safety needs of the individual. These needs may be met by a combination of specialized and non-specialized services, supports, and strategies; natural supports, or services and supports from non-Medicaid programs.

Further assessment may be required based on the outcome of initial assessment. If the team identifies an elevated risk to the person's health and welfare due to risk-taking behavior or a medical condition, additional steps must be taken to address behavioral or medical risk.

When the team has attempted to manage a behavior unsuccessfully or feel they don't have the information necessary to develop an appropriate management plan, it may be appropriate for assistance from a DDD psychologist to be requested. If any of the following factors exist, a risk assessment should be considered after the team's attempts to manage the behavior have been unsuccessful:
1. The individual has committed at least one physical attack towards another individual with intent to inflict severe physical harm; or three moderately aggressive acts which may be described as kicks, blows and shoving that does not cause severe harm to another person.
2. The individual has had sexual contact/conduct with a child or non consenting adult or other vulnerable person; the sexual contact would include touching or fondling the person as well as physical penetration with a body part or implement or forcing that person to perform sexual acts on self.
3. The individual has committed sever property destruction with the potential for injury to others, including destruction by fire.
4. The individual has had illegal or unsafe social behavior towards others, including prostitution, confrontational theft or robbery, threatening another person with a weapon, kidnapping/false imprisonment, or child enticement.

The primary intent of a risk assessment is to help the team understand the variables which could increase risk so that the team can incorporate these into programming to reduce risk. Central office management may determine that behavioral risk services are necessary and oversee the selection of a behavioral risk service provider.

When medical risk is identified, the need for medical risk services will be determined by designated staff at central office. A referral is completed by the individual's IFSP team to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of central office. When the team, which may include the individual's physician, believes that the individual's needs require medical risk services, the individual may be referred to DD central office for a formal health assessment. Medical history, current medical evaluations, and a formal health assessment are considered and recommendations or direction are provided to the team regarding optimal elements to consider when selecting or preparing service environments and treatment options that will best mitigate risks identified and support the individual. Central office management may determine that medical risk services are necessary and oversee the selection of a medical risk service provider.

If it is determined that the needs cannot be met under the current plan without posing a threat to the health and safety of the individual, the team may need to re-consider the appropriateness of the individual receiving his/her current waiver services. Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports may be accessed. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case by case basis.

Back up arrangements for the delivery of residential or day habilitation services by the DD provider agency are described in the provider's policies and procedures. Each agency has on-call or substitute staff available when a staff person fails to appear for work. Agency staff and/or parents have contact information for the DD agency's Manager or Coordinator who is responsible for scheduling and assigning on-call staff.

Back up arrangements for the delivery of habilitative child care and respite are determined on an individual basis. The need for and type of back up is discussed at the IFSP meeting and documented in the service plan. Consideration is given to the natural supports that may be available to fill in and the availability of other enrolled providers in the community who could deliver services. This information is documented in the service plan, provided to the state staff responsible for provider enrollment, and discussed at the time of each provider's enrollment. Back up arrangements for the delivery of habilitative child care and respite are determined on an individual basis at the time of the independent provider enrollment. Multiple independent providers may be enrolled as back up or substitute providers.

Information about back-up plans for the delivery of specialized habilitation services is provided by the DD provider agency to the individual and family or legal guardian when the IFSP is developed. Specialized services include group home habilitation, Integrated Community Employment, Prevocational Habilitation, Behavioral Risk, Day Habilitation, Companion Home Residential Habilitation, Extended Family Home Residential habilitation, In-Home Residential Habilitation, Medical Risk, Vocational Planning Habilitation, Workstation habilitation services, and Team Behavioral Consultation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Nebraska's services for individuals with developmental disabilities are voluntary, both for the individual and the provider. Choice of providers and services is based on mutual consent.

Nebraska has regulations and processes in place to ensure individuals are provided information about DD services and providers to facilitate informed decisions. DHHS offices are located throughout the state to provide a statewide system of service coordination.

The service coordinator provides the individual, and/or the family or legal representative, if applicable, information about or web addresses or links to local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD provider agencies, and non-certified independent non-specialized providers.

Information about local community services and supports, and how to access available services is provided to participants. Answers4Families is an internet family information and resource center, developed by DHHS in partnership with the University of Nebraska Center on Children, Families, and the Law. E-mail discussion groups are available and the directory (Nebraska Resource and Referral System) includes over 8,000 providers of services and supports in the state. Feedback on the site can be given instantly, with corrections the next business day, and every resource is updated every six months.

Ready, Set, Go! is a web-based series of materials and resources intended to assist in making decisions about supports for young adults with intellectual or developmental disabilities as they move for high school to adult life.

Some local Arcs, in collaboration with local public school's Special Education departments, Vocational Rehabilitation services, and Service Coordination offices also co-sponsor a "Provider Fair." Provider Fairs give the individual and his/her family/legal guardian an opportunity to meet area DD provider representatives and ask questions about philosophy, services, supports, etc. Service coordination representatives provide information about services provided by independent providers, such as the types of services and the provider standards.

Service coordination staff may assist the individual, family, and/or legal guardian to arrange interviews with potential providers. Service coordination staff may assist the individual, family, and/or legal guardian to arrange tours of potential specialized DD agency providers.

Families often draw from their personal networks of family members not living in the household, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students in order to select non-specialized providers.

When the individual is considering home modifications, the SC makes a referral to an approved provider to ensure that the referral is an appropriate modification, based on the service definition of the applicable service and the provider's established protocols.

Home modification service includes:
1. An assessment report, which is:
   A. A summary of needs and current support;
   B. Recommendations;
   C. Cost estimate and cost coordination, if needed; and
   D. Hiring and oversight of subcontractor;
2. If applicable, documentation of the orientation to and training on how to use the assistive equipment/support, which may include the delivery and/or installation dates;
3. Copy of signed subcontractor bill and signed consumer acceptance form; and
4. Narrative summary.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Health and Human Services is the Single State Medicaid Agency. All functions related to the IFSP development and approval are completed by DHHS staff.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) Service coordination is responsible for in-person, on-site monitoring of the implementation of the IFSP and individual health and welfare.

(b) Monitoring mechanisms include:
1. Documenting observations made during a planned monitoring visit or unscheduled visits;
2. A review of all components of the IFSP to ensure:
   A. Delivery of services, supports, and strategies in accordance with the IFSP, with additional monitoring of behavioral risk services or medical risk services if applicable;
   B. Individual access to wavier and non-waiver services identified in the service plan;
   C. Free Choice of provider(s);
   D. Services meet individual/family needs;

E. Effectiveness of back-up plans, if applicable and utilized;
F. Individual health and welfare;
G. Physical nutritional management;

3. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the IFSP is necessary;

4. A semi-annual review of the IFSP by the SC and the team in-person. The team must review progress, implementation of the IFSP, and the need for any revisions to the IFSP; and

5. Addressing concerns with the provision of services.

(c) Service Coordination will verify, through ongoing monitoring efforts, that the assistance provided continues to be effective in preventing recurring problems. Service Coordination monitors the implementation of each IFSP. This oversight has long been a part of the regulations, policies, and expectations regarding the role of service coordination in monitoring. In-person and on-site full reviews are conducted at least twice annually on each person in services with ongoing in-person and on-site monitoring conducted between the full monitoring. The current on-site monitoring tool is designed to review the implementation of the total IFSP after both the annual and semi-annual team meetings. Between these full monitorings, the SC conducts ongoing monitoring on-site and in-person. During each of these monitoring sessions, the SC may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

Follow-up and remediation process for issues discovered during monitoring:
Observations made during a review or "in passing" are documented. Should immediate safety concerns be evident, the concern will be expressed verbally to appropriate persons to prevent the individual served or others from being harmed. If it is necessary for the SC to intervene to ensure the health and/or safety of the individual, such incidents will be immediately discussed with the SC supervisor. Suspected abuse or neglect will be reported to Adult Protective Services and Child Protective Services as appropriate. Documentation will be completed.

Participant-directed non-specialized services include Homemaker, Respite, Community Living and Day Supports, and Habilitative Child Care. Service coordination observations during the delivery of participant-directed non-specialized services are discussed with the individual and/or family, as appropriate, and the provider, as appropriate, as soon as possible, and followed through to resolution. If resolved at this level, resolution will be documented on the monitoring tool or in service coordination narratives. A team meeting may be called to respond to monitoring issues and to adjust the IFSP if necessary.

Specialized services are not participant directed and include group home habilitation, Integrated Community Employment, Prevocational Habilitation, Behavioral Risk, Day Habilitation, Companion Home Residential Habilitation, Extended Family Home Residential habilitation, In-Home Residential Habilitation, Medical Risk, Vocational Planning Habilitation, Workstation habilitation services, and Team Behavioral Consultation. Observations made by the DD SC during the delivery of specialized services will be discussed with appropriate provider agency staff as soon as possible. If resolved at this level, the resolution is documented in the SC narratives. If the issue is not resolved, the SC will complete a Service Review Memo and send to the provider agency staff supervisor and Service Coordination supervisor (SCS). A response is requested within ten days from receipt of the memo.

When a response is received, the supervisor and SC will review the response to ensure that it meets the expectations in correcting the problem. If no response or an inadequate response is received, the SCS will copy the written documentation of noted concerns and send it to their local Service Coordination Administrator (SCA).
The SCA or designee will contact the Area Director of the provider agency to develop a mutually agreed-upon plan of action. If no resolution is achieved, or if trends show that the problems are recurring (such as "no ongoing habilitation provided," "programs not run as written," "programs not run at all," etc.) the SCA or designee will inform the Central Office of the problems. Central Office staff will review the concerns to determine what steps to take and will notify the SCA or designee. Central office staff may provide consultation/technical assistance to the DD provider agency, perform a focused certification or contract compliance review specific to the delivery of services to an individual or provider setting, or complete a complaint investigation.

During certification reviews conducted by DDD Surveyors, the IFSP is reviewed using the Core Sample Record Audit and, if behavior modification is a part of the IFSP, the Core Sample Review Checklist. Certification reviews are conducted annually, biennially, or as determined by DDD management staff.

In addition, the IFSP is reviewed annually to determine if the plan developed by the individual's team meets the individual's needs and also to determine if services are implemented in a manner that meets the individual's needs. Areas of services reviewed for example are health, safety, habilitation, and personal goals. The IFSP identifies services, supports, interventions, and strategies to be provided by the specialized DD provider agencies as well as services provided by non-specialized independent providers of DD services. When non-compliance issues are identified with the provider agency, the types of action that may be taken range from citing a deficiency to termination of the provider agency. The general action taken is a citation of a deficiency and the provider must provide an acceptable plan of improvement that addresses the issues cited for those individuals identified in the sample as well as address the issue cited on a system level within the specialized provider.

The information derived from monitoring the implementation of the IFSP and review of the IFSP is entered into a database. Designated DHHS staff has access to the database and may query the data to identify problems and trends.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service coordination monitorings, the number of monitorings that indicate medical issues are being addressed as documented in the IFSP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordination Monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the QI committee

Performance Measure:
Of the total number of service coordination monitorings, the number of monitorings that indicate safety issues are being addressed as documented in the IFSP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordination Monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify: semi-annually or as determined by the DDD QI committee

Performance Measure:
Of the total amount of IFSP reviews, the number of reviews that indicate medical services are specified and documented on the IFSP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Service Coordination Supervisor Program Plan Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the state QI committee

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service plans reviewed, the number of plans that have been determined to be written in accordance with identified DDD policies and procedures.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Service Coordination Supervisor Program Plan Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the SC Administratror or state QI committee

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service plans, the number of IFSPs developed by the team annually and reviewed semi-annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Service Coordination Supervisor Program Plan Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Specify: as determined by the state DDD QI committee

Performance Measure:
Of the total number of service plans/Individual and Family Support Plans developed each year, the number of service plans that were revised due to a change in a person's needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Service Coordination Supervisor Program Plan Review

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the State DDD QI committee

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of IFSP reviews, the number of reviews that indicate the number of units authorized matches state's electronic authorization and billing system.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Service Coordination Supervisor Program Plan Review

Responsible Party for data collection/generation*(check each that applies):*	Frequency of data collection/generation*(check each that applies):*	Sampling Approach*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the state QI committee

Performance Measure:
Of the total number of service plans, the number of plans that reflect services were authorized as specified in the plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordination Monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the local QA/QI committee or state DDD QI committee

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new waiver participants each year whose records contain an appropriately completed and signed Consent/Request for Services form which offered a choice between institutional and waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Review Worksheet and Quality Assurance File Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the state DDD QI committee

Performance Measure:
The number and percent of new waiver participants or their parent/guardian if the participant is a minor, that participated in making a choice of waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Service Coordination Supervisor Program Plan Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the State DDD QI committee

Performance Measure:
Of the total number of individual and family pre-service plan meetings conducted annually, the number of meetings that reflect the waiver participant was afforded choice between/among waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDD Service Coordination Supervisor Program Plan Review

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the state QI committee

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In Nebraska, the service plan for participants of this waiver is known as the Individual and Family Support Plan (IFSP). The Service Coordinator (SC) is responsible for facilitation and development of the IFSP.

SC Supervisors conduct a review of every IFSP (100% sample) and additional evidence of the IFSP process to ensure it meets the waiver and regulatory standards.
The process was developed to also ensure the IFSP is completed in accordance with timelines and to aggregate the results to identify issues at various levels of the division.

The DDD staff consider assessment information, the individual's personal goals, and the IFSP to determine if the services defined flow from the assessments and personal goals. This review includes not only the waiver services, but also the non-waiver services and other natural and community supports identified in the IFSP. When variances are noted, the SC Supervisor oversees the action taken by the SC to correct the IFSP.

If issues (i.e. institutionalized more than 30 days, loss of Medicaid eligibility, failure to utilize waiver services or failure to address health and safety requirements) are identified that will affect the waiver status of the individual, the SC is notified and given a date to respond. Failure to receive corrections will result in the removal of the person from the waiver and notification of the SC supervisor. Correction of the areas of concern may allow the person to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver support.

To allow for increased state oversight of the service plan review process, the responses are entered into a database. The database allows for SC Supervisors to have access to the information in aggregate form to look at the performance of individual SCs. This information is reviewed and acted on, as appropriate, at the local level.

In addition, Service Coordination monitors the implementation of each IFSP in its entirety twice annually in addition to the ongoing monitoring of the IFSP which may involve specific areas of

the IFSP within each monitoring session.
In this way, there is an extensive 100% review of the design and the implementation of every IFSP for persons receiving waiver services. Monitoring mechanisms include:
1. A review of all components of the IFSP to ensure delivery of services as specified by the IFSP;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the IFSP is necessary; and
3. A semi-annual review of the IFSP by the SC and the IFSP team. The team reviews progress, implementation of the IFSP, and the need for any revisions to the IFSP.

The monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC conducts ongoing monitoring. During each of these monitoring sessions, the SC may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the Service Coordination monitoring process, responses on the IFSP monitoring forms are currently entered into a web-based database. This allows individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, local Service Coordination Administrators, and the central office. The information is useful to the Supervisors and Administrators for looking at the performance of individual SCs and providers, as well for identifying any area wide issues. This information is reviewed and acted on, as appropriate, at the local level.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If issues are discovered that will affect the waiver status of the individual, the SC is notified and given a date to respond. The date of response is determined by the SC supervisor and varies between 5 working days and 10 working days, based on the nature of the issue. Failure to receive corrections may result in the removal of the person from the waiver and correction of the areas of concern may allow the person to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver status. There is no gap in services to the participant; services are funded by state general funds to ensure continuation of services, health, and safety.

The SC monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC conducts ongoing monitoring. During each of these monitoring sessions, the SC may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the SC monitoring process and the service plan review process, the responses are entered into a web-based database. This allows individual SCs to track issues that aren't resolved and for the SC Supervisors to have access to the information in aggregate form to look at the performance of individual SCs, and provide aggregate information for the SC Supervisors, local Service Coordination Administrators, and the central office. This information is reviewed and acted on, as appropriate, at the local level.

When issues or problems are discovered during a SC monitoring, the individual's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the individual, manager of services, and/or providers, etc. A timeline to address the issues and/or an IFSP team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the state DDD QI committee.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**
○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Opportunities for participant direction will be offered to individuals that choose non-specialized DD services. Non-specialized services are services directed by the individual or family or guardian when the youth is a minor, and delivered usually by independent providers. Family-directed or participant-directed services are intended to give the individual more control over the type of services received as well as control of the providers of those services.

The underlying philosophy of offering non-specialized participant directed services is to build upon the individual and family strengths and to strengthen and support informal and formal services already in place. Non-specialized participant directed services include Homemaker, Respite, Community Living and Day Supports, and Habilitative Child Care. DDD is embracing a self-directed philosophy, designed to provide choice when determining the services and supports that are needed to maximize the independence of the person with an intellectual or other developmental disabilities. The service coordinator is involved in supporting participant direction. The SC supports participant direction by meeting with the individual and family to facilitate discussion of the individual's budget, the participant directed services available to the individual, and responsibilities associated with choosing participant directed services. The SC may assist in locating independent

providers and facilitate interviewing the perspective providers. The SC facilitates and documents the IFSP meeting.

(b) The individual has the right and responsibility to participate to the greatest extent possible in the development and implementation of his or her plan. This person-centered plan (the Individual and Family Support Plan or IFSP) is individually tailored to address the unique preferences and needs of the person. Participants in the planning process will be determined by the individual/family or the legal representative, if applicable, but must at least include the individual/family, the service coordinator, the legal representative if there is one, and DD provider agency representatives when specialized DD services are provided. The IFSP must identify the needs and preferences of the individual and specify how those needs will be addressed. This must include identification of services and supports to be provided as well as services and supports to be provided by specialized (i.e. provider operated) services and other non-DDD funded resources. Non-specialized services may be utilized either alone or in conjunction with specialized DD services, and non-DD funded services and supports, as appropriate for, and determined by, the individual.

Individuals and/or their families have the right and responsibility to select potential independent providers as well as specialized provider agencies. The individual and/or their family identifies a potential provider; screens the provider to determine capability for delivery of non-specialized services, based on the waiver participant's needs and preferences, and the potential provider's experience, knowledge, and training; and describes supports to be delivered.

(c) Once the potential non-specialized provider is identified and screened, the individual or family contacts their service coordinator or designated DHHS staff to request enrollment of the provider. At anytime, the individual or his/her family can request assistance from the SC. The service coordinator may complete the above steps, as directed by the individual and/or family.

Once the non-specialized provider is enrolled and prior authorized for delivery of services, the individual and/or family directs the provider by setting the schedule and determining how the services will be delivered, and, based on the IFSP, the type and amount of community supports.

The individual also has the authority to "fire" the provider, by directing DHHS staff to end the authorization for the delivery of non-specialized services. DHHS has the option to retain the contract to allow other individuals to utilize the enrolled provider.

The DHHS is appointed the employer's agent as a means to ensure all requisite IRS rules are being followed. The participant or legal representative signs the form IRS-2678 to appoint the state as the employer's agent. This form is maintained by DHHS and kept in the participant's file in a DHHS office. Information regarding IRS related responsibilities is explained verbally and in writing to the participant and provider.
Participants are not liable for tax liabilities.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [x] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- ( ) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- (●) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Additional criteria that excludes participant-direction:

1) Person meets eligibility criteria for Behavior Risk services;
2) Person meets eligibility criteria for Medical Risk services; or
3) Person chooses Continuous services that are controlled and operated by the DD provider. Continuous habilitation services are services provided in a provider operated setting where there are DD provider staff on-site or within proximity to allow immediate on-site availability at all times to the individual receiving services, including during the individual's sleep time, when applicable. Staff must be present and awake during the times that individuals are present and awake. Continuous habilitation services include Group Home Residential Habilitation, Extended Family Home Residential habilitation, Companion Home Residential habilitation, Prevocational Habilitation, Day Habilitation services, Behavioral Risk, Medical Risk, and Workstation habilitation services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) Information about participant direction opportunities is available to individuals who are currently receiving DD services as well as to any individual entering DD services. Information is provided to the individual prior to entrance to the waiver and prior to the annual service plan development meeting to allow sufficient time for the participant to weigh the pros and cons of participant direction and obtain additional information as necessary. Information about participant direction opportunities is available in a consumer handbook, pamphlet, the DHHS web site, and other public communications, such as information from Nebraska Department of Education about post high school opportunities and information developed through the Nebraska DD Council.

The consumer handbook is utilized as a training tool and post-training reference guide for individuals and his/her support system. The consumer handbook includes the purpose of the handbook, an overview of non-specialized services, and tips for determining the appropriateness of participant directed services and supports, developing a plan, and putting the plan into action. The consumer handbook also includes tips for finding the right provider, participant liability (e.g. participants are not liable for tax liabilities), preparing for an emergency, and additional resources. Additional information available includes the IFSP, the Semi-annual review, budget worksheet, and provider handbook, budget tracking forms, state regulations, and provider calendars.

(b) Training was provided to individuals and families, and DHHS staff by DDD central office staff. Information about non-specialized supports was added to the Service Coordination new hire training, and presentations about non-specialized supports are provided by DDD central office as requested.

(c) The participant's service coordinator will provide ongoing information about participant - directed services and supports to individuals and families annually at the Individual and Family meeting prior to the annual IFSP and in response to inquiries.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appointment of a representative is a voluntary appointment and the representative is appointed by the participant or legal representative. The responsibilities and extent of decision making authority exercised by the representative is determined by the participant and his/her team and documented in the IFSP.

Service coordination provides monitoring to ensure that the representative functions in the best interest of the participant.

The representative may not also be paid to provide waiver services to the pariticpant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Community Living and Day Supports	☑	☐
Respite	☑	☐
Homemaker	☑	☐
Habilitative Child Care	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- ○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - ☐ **Governmental entities**
  - ☐ **Private entities**

- ◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

- ☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

  Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

  All DD service coordinators are qualified to provide self –direction guidance. In addition to the basic SC training, DDD SCs receive training on the self directed services that are available, such as the types/definitions of services; limits on the amount, frequency, or duration; authorization codes and rates; budget projecting; budget tracking; and the referral process for enrollment of independent providers. The SCs also receive the consumer handbook as a training tool.

  In addition to the basic SC duties performed by service coordinators, the SC provides supports for those who self-direct Habilitative Child Care, Homemaker services, Community Living and Day Supports, and/or Respite services. The SC will review the consumer handbook with the participant and their representative if applicable to assist the individual in understanding their responsibilities in hiring, training, screening claims, and dismissing a provider, as well as assisting the individual to recognize potential abuse and neglect situations.

  The SC will provide the amount of funding available to the participant and develop the monthly budget with the participant and representative. When determining the rate for an independent provider, the service coordinator and participant and/or representative develop the budget together. The participant is informed of their annual funding allocation and the range of rates to be considered, based on the potential provider's experience and training, and the participant's needs and tasks that the potential provider will perform.

  The SC keeps track of monthly expenditures and provides the amount of expenditures to the participant on a quarterly basis or immediately when expenditures exceed the monthly projected budget.

  If the participant has not chosen their provider(s), the SC will provide a list of currently enrolled independent providers for the participant to select from, and interview the potential provider with the waiver participant if the participant requests assistance. The SC follows through with DHHS staff responsible for provider enrollment to ensure that the provider is enrolled and authorized to provide the selected services to the participant.

  If requested the SC will assist the waiver participant in communicating to the independent provider his/her expectations of what and how the services will be delivered as well as any performance issues that may arise.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vocational Planning habilitation service	☐
Team Behavioral Consultation	☐
Behavioral Risk Service	☐
Workstation habilitation services	☐
In-Home Residential Habilitation	☐
Community Living and Day Supports	☐
Integrated Community Employment - Individual Employment Support	☐
Extended Family Home Residential Habilitation	☐
Companion Home Residential Habilitation	☐
Respite	☐
Day Habilitation	☐
Homemaker	☐
Group Home Residential Habilitation	☐
Home modifications	☐
Habilitative Child Care	☐
Medical Risk services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Nebraska's DD services are voluntary services, for the participant as well as the provider. An individual can voluntarily terminate participant direction by informing his/her SC.

Each person's funding amount is based on an objective assessment process, and each participant or his/her legal guardian can choose the types of services and the providers to meet their needs and preferences. The authorization of funding for services to a particular provider or providers is mutually agreed upon, and either entity can end participation. All DD providers are waiver providers.

Funding is determined using an objective assessment process, and the funding follows the individual.

Nebraska offers provider managed services under this waiver and another HCBS waiver for adults with developmental disabilities. The individual or his/her legal guardian may choose provider managed services (i.e. specialized services) that may better meet their health and safety needs. The provider managed waiver services are delivered by certified DD provider agencies and the team process is utilized in assisting the individual or legal representative in choosing waiver services and providers that may better meet his/her needs. Individuals can receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

State regulations allow the state to deny or end funding for participant directed services when:
1. An individual's needs are not being met through waiver services or intensity of services and supports does not reflect the need for ICF level of care.
2. The individual or legal representative has failed to cooperate with, or refused the services funded by DDD; or,
3. The IFSP has not been implemented.

The decision to end participant directed services may be based on Service Coordination monitoring, review of the individual program plan, reported incidents, assessment of risk to the individual and/or community, and complaint investigations conducted by the DHHS staff.

Nebraska offers provider managed (aka specialized) services under this waiver and another HCBS waiver for adults with developmental disabilities. The individual or his/her legal guardian may choose provider managed services that may better meet their health and safety needs. The provider managed waiver services are delivered by certified DD provider agencies and the team process is utilized in assisting the individual or legal representative in choosing waiver services and providers that may better meet his/her needs. Individuals can receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	95	
Year 2	115	
Year 3	120	
Year 4	125	
Year 5	145	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**
☐ **Determine the amount paid for services within the State's established limits**
☐ **Substitute service providers**
☐ **Schedule the provision of services**
☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
☐ **Identify service providers and refer for provider enrollment**
☐ **Authorize payment for waiver goods and services**
☐ **Review and approve provider invoices for services rendered**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Notice is made in writing, using the state's form titled Notice of Decision. State DD staff are responsible for issuing the Notice of Decision. State DD staff may be a DD Service Coordinator (SC), DD SC Supervisor, DD SC Service District Administrator or their designee, a Disability Services Specialist (DSS), or the Community Based Services Administrator or her designee. The state does not provide assistance to individuals in pursuing a Fair Hearing.

Initially, annually, and with each Notice of Decision the individual and his/her legal representative are informed of and receive a copy of the right to appeal. Notice must be made of an adverse action when choice of HCBS waiver, provider, or service is denied, and when there is denial, reduction, suspension, or termination of service. A written notice of any decision made by DDD staff is sent to the participant and/or legal representative.

The SC and the DSS provide written and verbal information to individuals. Included in the information provided are assurances that services will continue or be reinstated should the adverse action be contested by requesting an informal dispute resolution (IDR) meeting or a fair hearing. As applicable, the participant's rights are translated and provided in their primary language. DHHS has a statewide toll-free number for reporting allegations of neglect, abuse, and exploitation that is available 24/7.

In addition, advocacy groups, such as Nebraska Advocacy Services, People First, and The Arc have provided training on rights, exercising rights, voting, and due process.

Notices of adverse action and the opportunity to request a fair hearing are kept in the individual case file in the DDD SC's office or are kept in an electronic database.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**

◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

DHHS-DDD operates the dispute resolution process.

(a)When requested by the individual or his/her legal representative, an Informal Dispute Resolution (IDR) meeting may be arranged in accordance with state regulations. Any decision regarding the individual's eligibility or funding for services may be disputed by the individual or legal guardian. The issues usually disputed include ineligibility for DD-funded services, denial of immediate funding, or denial of an increase in funding for services currently being provided.

IDR meetings are facilitated by DDD central office staff acting on behalf of the DDD Administrator. The participant is informed in writing annually that the informal dispute resolution is not a pre-requisite for a Fair Hearing. The state regulations are available to the individual and legal guardian upon request.

(b)The request for an IDR meeting, if requested within 90 days of receiving notice of the decision being disputed, stays the adverse action as well as the deadline for filing an appeal, or fair hearing. Informal dispute resolution meetings are scheduled promptly, and may be scheduled with assistance by the individual's DD service coordinator. The IDR meetings are generally held in the local service coordination office or by conference call to accommodate all parties.

The meetings are generally attended by the individual and/or their legal representative, a DDD central office staff person who hears the complaint, gathers any additional information, and explains the eligibility and funding process and the person's further appeal rights, the individual's service coordinator and other service coordination administrative staff when applicable, and any provider staff or other advocates the individual or legal representative may ask to attend. All are encouraged to offer their perspectives regarding why the decision should be affirmed or reversed. The circumstances of the original situation are reviewed and additional information is often obtained, which is then reviewed by the DDD Administrator, and the original decision is either affirmed or reversed.

The decision is forwarded to the individual and/or their legal representative within one business day of the DDD Administrator's decision by the SC or disability services specialist.

c) The individual and/or their legal representatives have the option of continuing on to the formal appeal hearing or dropping their request.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

◉ **No. This Appendix does not apply**
○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDD defines incidents reportable by specialized providers as allegations or occurrences of abuse, neglect, and exploitation; events that cause harm to individuals; and events that serve as indicators of risk to participant health and welfare. DDD also tracks public complaints related to providers or participants.

All suspected abuse and neglect reportable under Nebraska state statutes are required to be reported to DHHS Protective Services or law enforcement. Suspected abuse and neglect may be reported by a toll free abuse and neglect hotline that is available 24/7 and posted on the DHHS website. Reports of suspected abuse and neglect are also accepted by e-mail, FAX, or letter.

Nebraska State Statute 28-710: "Child abuse or neglect means knowingly, intentionally, or negligently causing or permitting a minor child to be:
Placed in a situation that endangers his or her life or physical or mental health;
Cruelly confined or cruelly punished;
Deprived of necessary food, clothing, shelter, or care;
Left unattended in a motor vehicle if such minor child is six years of age or younger;
Sexually abused; or
Sexually exploited by allowing encouraging or forcing such person to solicit for or engage in prostitution, debauchery, public indecency, or obscene or pornographic photography, films, or depictions.

Out of home child abuse or neglect means child abuse or neglect occurring in day care homes, foster homes, day care centers, group homes, and other child care facilities or institutions."

Nebraska State Statue 28-711 mandates the following entities to report child abuse and neglect: "any physician, medical institution, nurse, school employee, social worker, or other person."

In Nebraska, children's DD waiver participants who are 19, 20, and 21 are considered adults. Nebraska State Statute 28-351 defines adult abuse: "Abuse means any knowing, intentional, or negligent act or omission on the part of a caregiver, a vulnerable adult, or any other person which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of essential services to a vulnerable adult."

"Exploitation means the taking of property of a vulnerable adult by means of undue influence, breach of a fiduciary relationship, deception, or extortion or by any unlawful means."

Nebraska state statue 28-372 mandates the following entities to report adult abuse, neglect, and exploitation: "any physician, psychologist, physician assistant, nurse, nursing assistant, other medical, developmental disability, or mental health professional, law enforcement personnel, caregiver or employee of a caregiver, operator or employee of a sheltered workshop, owner, operator, or employee of any facility licensed by the Department of Health and Human Services Division of Public Health (DPH), or human services professional or paraprofessional not including a member of the clergy."

An on-line reporting and tracking method for critical events or incidents was implemented in April 2011 to allow for coordinated responses, more frequent analysis of the data, and coordinated efforts

for remediation activities and follow-up. DDD also utilizes the Document Library in SharePoint, an intranet application of the Microsoft Outlook software, to store current forms, policies, and procedures. This allows utilization by service coordination and central office staff.

Nebraska guidance in reporting incidents for certified DD provider agencies is as follows:
Allegation of abuse, neglect, or exploitation
Injuries with severity level of Severe (Hospital, ER/admission)
Injuries with severity level of Death
Injuries with cause undetermined
Deaths of persons served.
Law enforcement involvement initiated by staff persons employed by the provider or by people in the community who report concerns about the provider's services.
Fire attempted/caused by individual
Hospitalizations (Admission or ER w/o admission)
Suicide attempts/threats
Use of chemical, physical, or mechanical restraint
Unplanned Emergency Safety Intervention
An individual served leaving staff supervision where the safety of the individual or others is potentially threatened. (AWOL/Missing Person)
Injuries with severity level of Moderate (Nurse/Physician treatment)
Possible Criminal Activity/Misconduct
Use of Emergency Safety Intervention included in the Safety Plan

A report of the above incidents is made to DDD immediately upon the provider, participant, or family becoming aware of the incident.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from abuse, neglect, and exploitation is provided to participants and his/her legal representative by his/her Service Coordinator. The information is provided verbally or in writing and may include discussion of what abuse, neglect, and exploitation is, the statewide toll-free number that is available 24/7, or community resources such as Nebraska Advocacy Services, People First, and The Arc that provide training on personal safety, rights, exercising rights, voting, and due process.

Individualized training is delivered by the provider(s) and may include personal safety; recognizing and avoiding abuse, neglect, and exploitation; self-advocacy skills, etc.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Currently verbal reports of incidents are made to DDD by providers immediately upon the provider becoming aware of the incident. The verbal reports are followed up with written reports within 24 hours of the verbal report being made.

An on-line reporting and tracking method for critical events or incidents was implemented in April 2011 to allow for coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. DDD also utilizes the Document Library in SharePoint, an intranet application of the Microsoft Outlook software, to store current forms, policies, and procedures. This allows utilization by service coordination and central office staff.

Reports of incidents are made to DDD by phone by certified provider agency (Contractor) staff persons immediately upon the Contractor becoming aware of the following types of incidents. DDD staff triage the reports daily and determine the appropriate response which depends upon the type and frequency of the incident. See G-1.b. for information on the type of incidents which must be reported.

DDD receives automated alerts on calls made to the DHHS "hotline" for reporting alleged abuse/neglect. DDD staff triage/review the information and make a determination whether the incident reported to the hotline needs to be addressed by DDD Administration. Depending on the severity of the incident, the response by DDD ranges from recording the incident in a tracking database to conducting a complaint investigation.

Timeframes for conducting, completing, and informing the participant of the results of an investigation completed internally by the certified DD provider are determined by the DD provider agency and are outlined in the DD provider's policies and procedures. Providers must develop a system in accordance with 404 NAC 4-010. Timeframes vary depending upon the involvement of law enforcement, the nature of the reportable event, and the legal status of the alleged victim (e.g. State ward).

Each certified DD provider agency submits an aggregate report of reportable incidents to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and administrative evaluation of incident trends over time.

An aggregate report of reportable incidents statewide is prepared for the DDD QI committee on a quarterly basis. The QI committee for DD Services reviews the reports and makes recommendations to the DDD management if necessary.

Child and Family Services (CFS) Specialists in the DHHS Division of Children and Family Services investigate and assess reports of child abuse and neglect involving children ages birth through seventeen. These reports have been screened by the Intake Unit (Hotline) to assure that the report meets statutory and regulatory criteria for DHHS intervention into the family in the interest of children.

Reports received and accepted for assessment are given a designated priority which reflects the time in which the CFS Specialist is to have face-to-face contact with the alleged child victim.

Priority 1 reports involve situations that suggest live threatening conditions or danger to the children. Priority 1 reports require contact within 0 to 24 hours. If a CFS Specialist is not available immediately, law enforcement is asked to respond to protect the child.

Priority 2 designations involve situations that are serious, but not life threatening. CFS Specialists are to meet with the alleged victim within 0 to 5 calendar days. Examples of Priority 2 intakes might be ones involving physical injuries or excessive discipline, or situations involving younger children.

Priority 3 designations require contact with the alleged victim within 0 to 10 calendar days. Priority 3 designations involve reports of physical discipline with only minor injuries, poor home conditions when the children are older, or situations where the perpetrator does not have access to the alleged victim.

All assessments are to be completed within 30 calendar days, although some situations may require a longer period of time. At the conclusion of the assessment, the CFS Specialist determines if there are safety threats or ongoing risk for the child. The Specialist also determines if there was maltreatment as defined by statute and regulations. If so, a letter is sent to the identified perpetrator to notify him or her that his or her name will be entered on the state Child Abuse and Neglect Central Register. Information on the Register is not available to the public. If a background check is required, the individual whose name will be checked must complete a form to provide identifying information and giving the Department consent to inform the party requesting information if a report has been found or not. No other details are provided. Other Department CFS records are confidential and can only be released to statutorily designated advocacy agencies or accessed by signed court order.

Investigations of allegations of neglect and abuse that meet statutory requirements are performed by adult protective services (APS) staff when the individual is age 18 and older. A Priority 1 report of allegation of immediate danger of death or life-threatening or critical harm to a vulnerable adult, including death or other vulnerable adults still at risk, have a 60-day time frame in which to complete an investigation. Face-to-face contact must be made with the victim as quickly as possible and no longer than 8 hours. If APS staff cannot make immediate contact with the alleged victim, law enforcement must be contacted to request that they conduct an investigation and send a written summary of their investigation to the APS worker. Timeframes take into consideration that law enforcement may be involved in priority 1 reports and therefore may take longer for completion of an investigation.

A Priority 2 report of an allegation of danger of serious, but not life-threatening or critical, harm to a vulnerable adult have a 45-day time frame in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 5 working days of the receipt of the report into the local office.

Priority 3 reports allege harm to a vulnerable adult which is serious, but not serious enough to be considered Priority 1 or 2 and have a 45-day time frame in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 10 working days of the receipt of the report into the local office.

In accordance with state statutes, upon request or court order, information contained in the registry of adult abuse/neglect is released to the victim or other interested parties. Information to be released and to whom the information can be released is limited by statute and regulations. The victim or legal representative, the reporter of the alleged abuse/neglect, investigating law enforcement, the prosecuting county attorney, the victim's physician, legally responsible agency, defense counsel, the state's designated protection and safety system (i.e. Nebraska Advocacy Services), and state staff responsible for licensing child care programs may be provided information contained on the registry upon request. Upon request, a physician or the person in charge of an institution, facility, or agency making a legally mandated report will receive a written summary of the findings, and actions taken by the Department in response to the legally mandated report.

The State's regulations identify the relevant parties that may request the results of the investigation and these regulations are on the public website. Victims are informed of the release of information contained in the registry upon request at the time of the investigation by the investigator.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Developmental Disabilities is responsible for overseeing the reporting of and response to reportable incidents and events. The incident needs to be reported by phone immediately upon the provider, participant, or family becoming aware of the incident. Within 24 hours written reports of incidents are made to DDD, using an online standardized format. DDD staff triages/reviews online incidents report information and makes a determination whether a response to the report is necessary. Levels of response by DDD range from staff review to an investigation, such as ensuring that allegations of neglect and abuse have been referred to DHHS Protection and Safety or law enforcement, referring licensure issues to DPH, complete a focused certification review, or a contract compliance review. Currently the reports are entered into a database, and an aggregate report of these incidents is prepared by the DDD Central Office staff on a quarterly basis. The state QI committee reviews the reports and makes recommendations if necessary.

The provider must implement a system for handling incidents, and each incident report must include an action plan that includes the provider's immediate effort to address the situation and prevent recurrence. (404 NAC 4-008) On a systemic basis, the provider must also review and analyze information from incidents reports to identify trends and problematic practices which may be occurring and take appropriate corrective actions to address problematic practices identified.

An aggregate report of these incidents, prepared by each provider agency, is forwarded to DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in addressing systematic issues contributing to the incident.

A quarterly report is written and presented to the state DD Quality Improvement Committee. However, as noted previously, there may be immediate follow-up individual events.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In Nebraska, "restraint" means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement, normal function of a portion of the person's body or control the behavior of an individual. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are excluded as a restraint.

Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.

Physical restraints (except as noted below), seclusion, aversive stimuli, corporal punishment, verbal abuse, physical abuse, emotional abuse, denial of basic needs, discipline, or implementation of an intervention of an individual in services by another individual in services, or other means of intervention with the behavior that result in, or is likely to result in injury to the individual, are not allowable habilitation techniques. The use of mechanical restraints is prohibited. The use of physical restraints is prohibited, except in the case of an individual with a physical restraint program in place at the time of the enactment of new regulations in the state of Nebraska. Regulations effective July 16, 2011, specify that providers serving individuals with a physical restraint program in place at the time of the enactment of the regulations must, within 180 days of the enactment of the regulations, implement a program which eliminates the use of such restraints. The use of mechanical restraints is prohibited. PRN (as needed) psychotropic medications are prohibited. Chemical restraints - drugs, or psychotropic medications used solely for the purpose of modifying behaviors are not allowed. The regulations stipulate that psychotropic medications used solely for the purpose of modifying behaviors are not allowed and there must be a plan in place to reduce and eliminate the medication; and must be used in conjunction with a positive behavioral supports plan as outlined in regulations 404 NAC.

Physical restraint or separation from harmful circumstances or from individuals at risk can only be used as an emergency safety intervention when the person must be kept from harm (i.e., running into traffic, leaving a moving car or other serious, unusual, or life-threatening actions by the person). Protocols for the use of physical restraint and separation are written into state regulations and must be included in provider policies, procedures, and practices. An emergency safety intervention utilized pursuant to a safety plan is allowed to respond in an emergency safety situation, and is not used as a behavioral consequence and utilized pursuant to a safety plan is allowed to respond to an emergency safety situation.

In instances where the person must be kept from harm, the provider must use their reasonable and best judgment to intervene to keep the person from injuring him/herself or others. This may include the use of separation - hands-on guidance away from harm or to another area or room to safely protect the persons and others from immediate jeopardy or physical harm. An individual could be physically guided away from an area and staff may block the exit. The individual would always have line of sight supervision and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The person cannot be put in a room, with the door closed and no one watching him/her. All such incidents must be documented and reviewed by the individual's team and rights review committee to ensure that the emergency safety intervention was appropriate rather than an instance of restraint.

Psychotropic medications taken by the person due to a diagnosed mental illness (a dual diagnosis of a severe and persistent mental illness in conjunction with a developmental disability) must only be given by a physician who has authority in his/her scope of practice to determine the diagnosis. PRN (as needed) psychotropic medications are prohibited. When prescribed, psychotropic medications must be reviewed by the individual's team to determine if the benefits outweigh the risks and potential side effects and supported by evidence that a less restrictive and more positive technique had been systematically tried and shown to be ineffective. These medications must be reviewed by the rights review committee and the meeting minutes must document approval by the committee per state regulations. An annual review by the prescribing physician and a semi-annual review by the individual's team are required, and there must be clear and convincing evidence that the individual has a person-centered plan demonstrated by data and outcome measures. Use of the medication must be monitored and documented on an ongoing basis by the provider to provide the individual's team and physician sufficient information on effectiveness of and any side effects experienced from the medication. The individual must also have a positive behavioral supports plan established and in place to address symptoms when they occur if symptoms reappear and ongoing use of the medication is no longer effective.

Psychotropic medications cannot be used as a way to deal with under-staffing or as a way to deal with ineffective, inappropriate, or other nonfunctional programs or environments. Psychotropic medications used solely for the purpose of modifying behaviors may only be used in accordance with the previous paragraph and there is a plan to reduce and eliminate the medication, and it is used in conjunction with a positive behavioral supports plan as outlined in the regulations.

The provider must establish a Review Committee to provide prior review and approval of all behavior support plans, safety plans, and emergency interventions that use chemical restraints to modify behavior, physical restraints, or separation. The effectiveness of the intervention in conjunction with the behavior support plan must be monitored and reviewed. The Review Committee must have persons qualified to evaluate behavior support research and a physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications.

Staff must be informed of potential side effects, in non-technical terms, so that staff can monitor for early detection of side effects. Reports must be made to the physician based on this review.

When a drug is prescribed without prior knowledge and approval of the team or review committee, the drug is administered as prescribed. Development of, or revisions to a behavioral support plan and the committee's review and approval must be completed within 30 days.

Medications must be documented in the IFSP with the name, dosage, reason for, and the specific behaviors to be affected by the medication; whether the use of the drug was reviewed by the agency's review committee; and whether the drug is reviewed on an ongoing basis by a physician. Medication to manage behavior must be used only in dosages that do not interfere with the person's ability to take part in habilitation and daily living activities. The use of medication is documented after each drug administration.

The IFSP must include that a less restrictive and less intrusive method had been tried and systematically applied and determined to be ineffective before use of chemical restraints or emergency safety interventions such as physical restraints or separation for the purpose of modifying behavior. The team must evaluate and document that harmful effects of the behavior

clearly outweigh any potential harmful effects of the use of restraints or separation.

Providers must provide orientation of the agency as well as to each person's services. Orientation to each person's services must specifically include the procedures to be implemented, including the use of chemical restraints, physical restraints, or separation for the purpose of modifying behavior, and provided prior to implementation of the procedures. Providers must train staff prior to assuming their duties. Topics include the philosophy, organization, services, practices and goals of the agency, including the use of chemical restraints, physical restraints, or separation for the purpose of modifying behavior; person rights; abuse and neglect; individual program planning, including individualized assessments, base lining, data collection, writing habilitation programs, selecting training materials, and reinforcement types and schedules; medication administration (must be completed prior to administration of drugs); basic first aid; CPR; respite care; recordkeeping; and on-the-job training. Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to persons. This training must include:
1. Implementation and development of the IFSP and interdisciplinary process;
2. Positive support techniques; and
3. Approved emergency safety intervention techniques.

DD provider staff that administer drugs must meet the competency standards defined in Title 172, Chapter 95, Regulations Governing the Provision of Medications by Medication Aides and other Unlicensed Persons. The competency standards are listed in Appendix G-3-C-ii.

The methods for detecting the unauthorized use, over use, or inappropriate/ineffective use of emergency safety interventions or separation, and behavior modifying drugs and ensuring that all applicable state requirements are performed by state staff and are as follows:
a. Review and approval of each DD provider's policies and procedures during the provider enrollment process;
b. On-site certification review activities;
c. Review of critical incident reports;
d. Review of reports of events;
e. DDD Service Coordination monitoring;
f. Complaint investigations; and
g. Reports of allegations of abuse/neglect to adult or child protective services.

See G-2-a-ii below for complete description of methods for detecting the unauthorized use of all restraints and seclusion/separation.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHHS DDD is responsible for overseeing the prohibition on the use of restraints and ensuring that the state's safeguards are followed.

The methods for detecting the unauthorized use, over use, or inappropriate/ineffective use of emergency safety interventions or separation, and behavior modifying drugs and ensuring that all applicable state requirements are performed by state staff and are as follows:
a. Review and approval of each DD provider's policies and procedures during the provider enrollment process;
b. On-site certification review activities;
c. Review of critical incident reports;
d. Review of reports of events;
e. DDD Service Coordination monitoring;
f. Complaint investigations; and
g. Reports of allegations of abuse/neglect to adult or child protective services.

The provider's policies and procedures must be based on state regulations applicable to the use of psychotropic medications and emergency safety interventions of physical restraint or separation.

Monitoring of these safeguards is undertaken through on-site scheduled and/or unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-i for additional information.

Detection of unauthorized use of restraints may occur at the time of provider enrollment. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of emergency safety interventions and separation in emergency safety situations. The provider must have an internal quality review system and a Review Committee. When DDD program staff find policies and procedures that do not comply with regulatory requirements, such as unallowable intervention techniques, an insufficient QI system, an inadequate Review Committee, etc., the provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD. Provisional certification of a new provider agency will not be granted until the Division approves the applicant provider's policies and procedures.

Detection of unauthorized use may occur through on-site certification review activities, which may be unannounced or scheduled. During a scheduled certification review conducted by DDD, delivery of service is reviewed as well as the agency's systems. At least 1 person included in the targeted sample must be taking psychotropic medication. At a minimum, 33% of the sample includes persons taking behavior modifying medications. The sample is never of only one person and always includes at least three. Based on observations and findings, certification staff may pull additional people into the sample related to medications or other issues, and will review all pertinent documentation for those people as well. .Certification staff use onsite checklists to assure consistent review and consideration prior to, during, and following the visit.

Detection of unauthorized use of restraints may occur during unannounced site visits, or "walk-throughs". Observations are documented and may result in an investigation at the site. If aggressive behaviors, rights restrictions, or injuries are observed, for example, DDD staff will question provider staff and review individual files, which may reveal unauthorized interventions, inappropriate interventions, or injuries of an unknown nature.

Reporting of incidents is another method to detect unauthorized use of restraints. Providers must report incidents involving restraint. A verbal report must be made immediately upon the provider becoming aware of the incident and the verbal report is followed up with a written report within 24 hours or the verbal report being made. In April 2011, the state implemented on-line reporting methods for reporting incidents. Providers must file a written report of reportable incidents within 24 hours by entering it into the state sponsored online incident reporting system. These online reports are reviewed daily by Service Coordination and Certification staff to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance.

DDD Service Coordination monitoring may detect unauthorized use of restraints. Monitoring by Service Coordination of all persons receiving services is designed to review the implementation of each person's IFSP after both the annual and semi-annual team meetings. Between these scheduled full monitoring visits, the Service Coordinator conducts ongoing unannounced monitoring, which allows for focused monitoring if issues have been raised or are noted during the time of a full monitoring.

Complaint investigations and investigations of allegations of abuse or neglect performed by DHHS staff may also reveal unauthorized use of restraints.

Action that is taken by the State if it is determined through an investigation that unauthorized restraints/inappropriate interventions/unknown injuries are discovered may include an deficiencies cited requiring a provider plan of correction to be implemented, and may include follow-up onsite visits. Action may also include requiring the provider to seek training mandated by the State, placing the provider on probation, limiting admissions, or recoupment of payments made to the provider.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.

Provider agencies are required to report to the DD Division, both verbally and in writing, any use of chemical, physical, or mechanical restraint as well as planned and unplanned emergency safety interventions. The Division has provided an online web-based secure system for reporting incidents of the use of restraints. An aggregate report of the incidents, prepared by each provider agency, is forwarded to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance with the intent to reduce the number of incidents over time. The DDD QI committee reviews statewide quarterly reports compiled from the statewide database of incidents and events, which identify the types and numbers of incidents reported by providers on a statewide basis to assess areas of concern and improvement, and make recommendations for follow-up. To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into an internal web-based database. This allows for aggregate information for Service Coordination Supervisors, Service Coordination Administrators, and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local level with appropriate feedback or reports being provided to the DDD central office staff on a quarterly basis.

A report of complaint investigations is completed by DDD and, for licensed DD provider agencies, the Division or Public Health. These reports are prepared by the Divisions of Developmental Disabilities and Public Health, and then reviewed on a semi-annual basis by the DDD QI Committee. The reports include the number and type of complaints, as well as the disposition of each complaint.

Complaint reports received are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused review, contract compliance review, technical assistance, or a request for information from the implicated provider agency related to the complaint. The DDD QI committee reviews statewide quarterly aggregate

reports compiled from the statewide database of incidents, which identify the types and numbers of incidents by provider, areas of concern and improvement, and make recommendations for follow-up. The frequency of the oversight activities varies by activity.

The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. "Walk-through" activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Daily, on a Monday – Friday basis, each critical incident is reviewed by local state service coordination staff as well as by DDD central office staff.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions that are permitted include an action or procedure that limits an individual's movement, a person's access to other individuals, locations, or activities, or restricts participant rights.

To the fullest extent possible, an individual's rights may not be suspended or restricted. The restrictive measure determined necessary for one individual must not affect other individuals who receive services in that setting. Restrictive methods used should not be employed as punishment, for the convenience of staff, a substitute for habilitation, or be reactive in design. The restrictive measure must be the least restrictive and intrusive possible and, if used, there must be a goal of reducing and eliminating the restrictive measure. Prior to proposing a restrictive measure, there must be documented evidence that other less restrictive methods had been regularly applied by trained staff, and failed. The individual or their legal representative, if applicable, must give consent to the restrictive measure, it must be safe for the individual, and must be documented in the individual's plan. Prior to implementation of a restrictive measure, the provider must ensure review and approval by the individual's team and rights review committee as outlined in state regulations.

Protocols for the use of emergency safety interventions are written into state regulations and must be included in provider policies, procedures, and practices. An emergency safety intervention is not used as a behavioral consequence, but can be utilized pursuant to a safety plan is allowed to respond to an emergency situation. This is different from physical restraint because it is not used as a behavioral consequence. In instances where the individual must be kept from harm (i.e., running into traffic, leaving a moving car or other serious, unusual, or life-threatening actions by the person, the provider must use their reasonable and best judgment to intervene to keep the individual from injuring him/herself or others. In instances where the person must be kept from harm, the provider must use their reasonable and best judgment to intervene to keep the person from injuring him/herself or others. This may include the use of separation - hands-on guidance away from harm or to another area or room to safely protect the persons and others from immediate jeopardy or physical harm. An individual could be physically guided away from an area and staff may block the exit. The individual would always have line of sight supervision and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The person would not be put in a room, with the door closed and no one watching them.

The following documentation is required when restrictive interventions are used:
1. Written agency provider policies and procedures;
2. Written positive support plan to be used in conjunction with the restrictive measure, the criterion for the elimination of the restrictive measure, and method to collect data;
3. Written discussion and prior approval by the IFSP team and documentation the IFSP team's determination of the individual's ability to acquire, retain, or understand the information proposed in the restrictive measure;
4. Written informed consent;
5. Incident reports related to the use of restrictive interventions; and
6. Orientation, training, and/or competency standards for staff prior to implementation of restrictive measures.

Behavioral support plans must address behaviors that are obstacles to becoming more independent; that interfere with the ability to take part in habilitation; self-injurious behaviors; or behaviors that are a threat to others. The provider's policies and procedures must specify and define approved intervention procedures, and include a description of the mechanism for monitoring the use. The following components must be in place in a behavioral support plan, a safety plan, and in order to develop emergency safety interventions specific to each individual:
1. The functional assessments must define the communicative function of the behavior for the person and what purpose the behavior serves in the person's life;
2. A review of the person's day and residential supports and other relevant data must be incorporated in to the functional assessment process;
3. A safety plan for the person must be developed that emphasizes positive meaningful activities, individualized supports, and options that are incompatible with the behavior targeted for change;
4. The plan must include a description of potential stressors and triggers that may lead to the person experiencing a crisis, and then a comprehensive safety program developed and implemented;
5. The individual's safety plan must include the type of physical restraint and/or separation, the length of time the emergency intervention will be utilized in each instance, and the monitoring procedures that the staff will perform during each instance; and
6. There must be meaningful and individualized data collection and data analysis that track progress. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.
Prior written consent of the person or the legal representative must be obtained.

All DD agency providers must be in compliance with state regulations that govern the delivery of home and community-based services and licensing standards for centers for individuals with developmental disabilities (DD).

The provider must develop a policy specifying whether they allow for the use of restrictive measures. If the provider allows the use of restrictive measures, the written policies and procedures must include the following:
1. The restrictive measure determined necessary for one individual must not affect other individuals who receive services in that setting;
2. The restrictive measure must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation, or as an effective positive behavior support plan;
3. The restrictive measure must be the least restrictive and intrusive possible;
4. All restrictive measures must be temporary;
5. Prior to proposing a restrictive measure, there must be documented evidence that other less restrictive methods had been regularly applied by trained staff and failed;
6. The restrictive measure must be safe for the individual; and
7. Agency-approved restrictive measures must be specified and defined.

Restrictive measures can only be used as an integral part of a written habilitation strategy that is designed to lead to a less restrictive way of addressing the unacceptable behavior and ultimately to the elimination of the behavior for which the restrictive measure is used.

The provider must ensure that the written habilitative strategies stress positive approaches in addressing behaviors. The provider must have written policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each individual.

Methods for detecting the unauthorized use of restrictive measures include provider enrollment, on-site certification reviews, reporting of incidents, service coordination monitoring, and investigation of complaints. See Appendix G-2-a-i for a description of the methods.

Prior to implementation of a restrictive measure, the provider must ensure review and written approval by the IFSP team and rights review committee and written informed consent.

The provider must participate in the IFSP team process to discuss and review the proposed restrictive measure prior to implementation. The Individual Program Plan (IFSP) must document the IFSP team's determination of the individual's ability to acquire, retain, or understand the information proposed in the restrictive measure. The discussion and approval of the use of the restrictive measure including the following must be recorded in the individual's IFSP:

1. The proposed restrictive measures;
2. Methods previously tried and shown to be ineffective;
3. Risks involved with the restrictive measure and risk involved if no restrictive measure is used;
4. Rationale for the proposed restrictive measure;
5. Other possible alternative methods;
6. Description of the behavior support plan proposed to be used in conjunction with the restrictive measure to lead to elimination of the restrictive measure and the criterion for the elimination of the restrictive measure; and
7. Frequency that the individual's IFSP team will review the effectiveness of the plan, but not less than every six months. The IFSP team review must address:
a. The original reason for restrictive measure, current circumstances, success or failure of the positive support plan, and the rationale based on evidence for continued use of the restrictive measure; and
b. Decrease in the use or elimination of the restrictive measure as soon as circumstances justify, based on established and approved criterion in the IFSP.
The provider must obtain written informed consent from each individual or legal representative as applicable, for authorization to use a restrictive measure. The written informed consent must be obtained prior to implementation of the restrictive measure.

In addressing behaviors, the provider must develop and implement policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each individual. The provider must ensure the following behavior supports and emergency safety interventions for emergency safety situations:

The provider must assure that the following components of positive behavioral supports are in place:
1. The assessment must define the communicative function of the behavior for the individual;
2. The assessment must focus on what purpose the identified behavior serves in the individual's life;
3. A review of the individual's day supports, residential supports, and other relevant data must be incorporated in the assessment process;
4. A safety plan for the individual must be developed that emphasizes positive meaningful activities and options that are incompatible with the behavior targeted for change;
5. There must be a combination of a planned meaningful day and individualized supports for the individual;
6. The plan must include a description of potential stressors and triggers that may lead to the individual experiencing a crisis. Once identified, there must be a comprehensive safety program developed and implemented; and
7. There must be meaningful and individualized data collection and data analysis that track the progress of the individual. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.

The safeguards, practices, protocols, and documentation for the use of restrictive measures are the same as for the use of chemical restraints to modify behaviors, and the use of emergency safety interventions of physical restraint or separation. See G-2-a-i for additional information.

If restrictive, prior written consent of the person or the legal representative must be obtained, except in emergency situations.

Incidents related to the use of restrictive measures must be documented and reported. Reports of the following incidents must be forwarded to the local State DD Service Coordination:
1. Allegation of abuse or neglect;
2. Use of emergency safety intervention;
3. Discovery of an injury of unknown origin.

The provider must ensure that employees (including subcontractors and management) responsible for providing supports and services to individuals with developmental disabilities are educated/trained on the minimum requirements necessary to address the individual's needs prior to working with individuals in services.

Staff responsible for providing direct services must demonstrate the competence to support individuals as part of a required and on-going training program. The provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with individuals.

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas.

Initial orientation must be completed by all new employees prior to working alone with individuals. Employees must complete the following training requirements:
1. Individual's choice;
2. Individual's rights in accordance with state and federal laws;
3. Confidentiality;
4. Dignity and respectful interactions with individuals; and
5. Abuse, neglect, and exploitation and state law reporting requirements and prevention.

Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 days of hire or before working alone with an individual. The following training areas must be addressed:
1. Emergency procedures;
2. Cardiopulmonary resuscitation;
3. Basic first aid;
4. Infection control;
5. Individuals' medical protocols as applicable; and
6. Individuals' safety protocols as applicable.

Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to individuals. This training must include:
1. Implementation and development of the IFSP and interdisciplinary process;
2. Positive support techniques;
3. Approved emergency safety intervention techniques;
4. Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the individual;
5. Use of adaptive and augmentative devices used to support individuals, as necessary;
6. Other training required by the provider; and
7. Other training as required by the specific service options.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHHS DDD is responsible for monitoring and overseeing the use of restrictive measures.

The State-wide oversight responsibilities listed below employ the same methods described in Appendix G-2-a-i and G-2-b-i. Only additional information is included in this section regarding:
a. Review and approval of each DD provider's policies and procedures during the provider enrollment process;
b. On-site certification review activities;
c. Review of critical incident reports;
d. Review of reports of events;
e. DDD Service Coordination monitoring; and
f. Complaint investigations; and
g. Reports of allegations of abuse/neglect to adult or child protective services.
a. The provider's policies and procedures must be based on state regulations applicable to the use of restrictive measures.
b. Monitoring of these safeguards is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-i for additional information.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies. Improvement strategies are based on review of data such as by incident type, incident location, provider type, geographic area, individual(s) involved, etc. Trends or patterns that are identified may lead to increased monitoring, increased certification activity, or additional training to individuals, DDD staff, or DD providers to prevent re-occurrence.

a. An aggregate report of the reportable incidents and events, prepared by each provider agency, is forwarded to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of incidents over time. The DDD QI committee reviews statewide quarterly reports compiled from the statewide database of critical incidents and events, which identify the types and numbers of incidents by provider within a geographical area, identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

b. To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into a web-based database. This allows for individual Service Coordinators to track issues that are not resolved and provide aggregate information for Service Coordination Supervisors, Service Coordination Administrators, and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local level with reports being provided to the DDD central office staff on a quarterly basis.

A report of complaint investigations is reviewed on a semi-annual basis by the DDD QI Committee. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint.

The operation of the incident management system is overseen by DDD central office. An on-line reporting and tracking method for critical events or incidents was implemented in April 2011 to allow for coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. DDD also utilizes the Document Library in SharePoint, an intranet application of the Microsoft Outlook software, to store current forms, policies, and procedures. This allows utilization by service coordination and central office staff.

On-line reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance. The DDD committee reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types and numbers of incidents by provider within a geographical area, identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

The frequency of the oversight activities varies by activity.

The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. "Walk-through" activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Currently each incident is reviewed by DDD staff. Quarterly, the DDD QI committee reviews an aggregated report compiled from the statewide database of critical incidents and events.

DDD Service Coordination monitoring reports are provided to the DDD QI committees on a quarterly basis.

The DDD QI Committee reviews a report of complaint investigations performed by DDD on a semi-annual basis.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96). Compliance reviews of the provider are completed by the Division of Public Health within DHHS.

First line responsibility for monitoring participant medication regimens resides with the medical professionals that prescribe the medications, every time that the professional prescribe the medications. The medical professional that prescribes the medications determines the frequency of the monitoring, based on the individual's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues.

The monitoring of the appropriateness of each medication and the appropriateness of multiple medications is the responsibility of the medical professionals who prescribe them, the pharmacist who fills the prescriptions, and the provider's review committee.

Each provider must establish a committee to provide prior review psychotropic medications used solely for the purpose of modifying behaviors, and issues related to research involving clients, for the purpose of ensuring that client rights are not violated. The agency shall have a review committee which includes -
1. Persons qualified to evaluate behavioral research studies/proposals and the technical adequacy of proposed positive behavioral support plans; and

2. A physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications to modify behavior.

First line monitoring methods are carried out by the DD provider, and consist of documenting and reporting to the physician at every appointment, legal representative when requested, and the delegating licensed health care professional:
1) Unsafe conditions of medications;

2) Adverse reactions to medications;

3) Medication errors; and

4) Staff observations regarding the behavior which the medication has been prescribed to reduce.

The second line monitors are licensed health care professionals whose scope of practice allows delegation of medication administration. The health care professionals, usually Registered Nurses, delegate the administration of medication to medication aides. The licensed health care professionals are employees of the DD provider agency or who have entered into a contract with the DD provider.

Second line monitoring activities and frequency of monitoring is determined by the health care professional and the DD provider. The medical professional that prescribes the medications determines the frequency of the health professional's monitoring which may be monthly, quarterly, semi-annually, or annually and is based on the individual's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues. The DD provider's monitoring activities may include observation of the administration of medications or treatment; review of records relating to medication provision or treatment; review of incident reports related to medication or treatment errors; retraining, and continued observations.

Staff observations regarding the behavior which the medication has been prescribed to reduce are also reported to the provider's review committee when the positive behavioral supports plan for that individual is scheduled for review. Each DD provider must have policies and procedures that identify the frequency of monitoring.

In addition to meeting statutory and regulatory requirements, the DD provider agencies must have policies and procedures addressing the provision of medications, per applicable state regulations.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement that includes frequency of QA/QI monitoring activities. The QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action. The provider's reports of QA/QI activities are reviewed on-site when DDD completes a certification review, annually or every two years, based on the certification status of the provider.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DHHS Division of Public Health (DPH) is responsible for the oversight of compliance with the Neb. Rev. § 71-6718 - 71-6743, known as the Medication Aide Act. The administration of medication is a regulated activity as a method to ensure that participant medications are managed appropriately. The purpose of the Medication Aide Act is to ensure the health, safety, and welfare of individuals through accurate, cost-effective, and safe utilization of medication aides for the administration of medications. Medication aides and other unlicensed persons may help with the physical act and documentation of provision of medication; and, under specific conditions such persons may also assist with monitoring therapeutic effects. Medication aides must be recertified every two years.

The administration of medication by licensed health care professionals is regulated by their respective practice acts. Under these regulations, administration of medication in the home is regulated only if provided through a licensed home health agency or through certified home and community-based providers. These regulations do not govern self-administration of medication. These regulations do not govern the provision of medication in an emergency situation. Licensed home health agencies do not administer medications to waiver participants that receive provided operated waiver services. This section only applies to medications administered by certified DD agency providers.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:
a. Review and approval of each DD provider's policies and procedures during the provider initial certification process;
b. On-site certification review activities; and
c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDS program staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DDD. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of individuals served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including persons prescribed behavior modifying medication. The sample size ranges based on the number of individuals served at the site; however, it is never of only 1 person and always includes at least 3. From this certification review, it would be determined whether or not individuals receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff, a DD Surveyor, cites deficient practice in the certification report and the provider agency must submit formal Plan of Improvement (POI) addressing citations. The POI must be approved by DDD, and the provider is advised of changes that may be necessary to the POI. The POI must comply with regulatory requirements (404 NAC 4-002.10B) and be approved by DDD. The provider is advised of changes that may be necessary to the POI and upon receipt of an acceptable plan of improvement, the DDD may conduct an on-site revisit or request information form the provider to ensure resolution is completed.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five rights (Provides the right medication, to the right person, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property;

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of performance errors by individual Medication Aides and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry. Individual errors are not aggregated by DPH.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. On an ongoing basis, when a complaint involving the performance of a Medication Aide is received by the DPH by phone, FAX or on-line, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry. The risk of continued harmful practices is eliminated by removing the medication aide from the registry.

DDD service coordination monitors the implementation of the IPP, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual IPP and semi-annual IPP. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed verbally at the time of the discovery or in writing in a service review report.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96).

The purpose of the Medication Aide Act is to ensure the health, safety and welfare of individuals through accurate, cost-effective, and safe utilization of medication aides for the administration of medications.

Medication aides are persons that are unlicensed and provide medication administration only under the direction and monitoring of: 1) a licensed health care professional whose scope of practice allows medication administration; 2) a recipient with capability and capacity to make informed decision about medications for his/her medication (i.e. self-administration); or 3) a caretaker. Caretaker means a parent, foster parent, family member, friend, or legal guardian who provides care for an individual. A caretaker provides direction and monitoring and has capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

A caretaker has current first-hand knowledge of the recipient's health status and the medications being provided, and has consistent frequent interaction with the recipient. A staff member of a facility, school, or other entity is not a caretaker.

The ability to self administer medication means that the individual is physically capable of:

a. The act of taking or applying a dose of a medication;

b. Taking or applying the medication according to a specific prescription or recommended protocol;

c. Observing and monitoring him/herself for desired effect, side effects, interactions, and contraindications of the medication, and taking appropriate actions based upon those observations;

d. Receiving no assistance in any way from another person for any activity related to medication administration.

The inability to self administer medications means the individual:

a. Is not at least 19 years of age. Minor children may take their own medication(s) with appropriate caretaker monitoring;

b. Does not have cognitive capacity to make informed decision about taking medications;

c. Is not physically able to take or apply a dose of a medication;

d. Does not have capability and capacity to take or apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for nonprescription medication; and

e. Does not have capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

The DD provider agency must evaluate an individual's medication administration abilities, and determine the level of assistance needed for medication administration.

For recipients who do not have the capability and capacity to make informed decision about medications and for whom there are not caretakers, acceptance of responsibility for direction and monitoring must be provided by a licensed health care professional.

Documentation may be accomplished by any of the following methods:
(1) When licensed health care professionals are employees, entities may identify on an individual basis or by title and job description/role delineation the licensed health care professional or the classification(s) of licensed health care professionals who are responsible to provide direction and monitoring. Written acceptance of responsibility is not required to be recipient specific and can be through acceptance of title and job description/role delineation.

(2) When licensed health care professionals are not employees, entities must identify the licensed health care professional by name, profession, and license number who is designated to provide direction and monitoring. Written acceptance of responsibility needs to be recipient specific.

(3) A licensed health care professional who provides services directly to a recipient for direction and monitoring, rather than indirectly through facility employment, needs to have a written contract with the recipient or other responsible party on behalf of the recipient which identifies acceptance of said responsibility.

The minimum competency standards are defined in regulations. Medication aides and other unlicensed persons who provide medication must:

(1) Recognize the recipient's right to personal privacy regarding health status, any diagnosis of illness, medication therapy and items of a similar nature. Information of this nature should only be shared with appropriate interdisciplinary team members.

(2) Recognize and honor the right of those recipients, with capability and capacity to make an informed decision about medications, to refuse medications and at no time to be forced to take medications. In the case of a recipient who does not have the capability and capacity to make informed decision about medications, recognize the requirement to seek advice and consultation from the caretaker or the licensed health care professional providing direction and monitoring regarding the procedures and persuasive methods to be used to encourage compliance with medication provision. Recognize that persuasive methods should not include anything that causes injury to the recipient.

(3) Follow currently acceptable standards in hygiene and infection control including hand washing.

(4) Follow facility policies and procedures regarding storage and handling of medication, medication expiration date, disposal of medication and similar policies and procedures implemented in the facility to safeguard medication provision to recipients.

(5) Recognize general unsafe conditions indicating that the medication should not be provided including change in consistency or color of the medication, unlabeled medication or illegible medication label, and those medications that have expired. Recognize that the unsafe condition(s) should be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(6) Accurately document medication name, dose, route, and time administered, or refusal.

(7) Provide the right medication, to the right person, at the right time, in the right dose, and by the right route.

(8) Provide medications according to the specialty needs of recipient's based upon such things as age, swallowing ability, and ability to cooperate.

(9) Recognize general conditions, which may indicate an adverse reaction to medication such as rashes/hives, and recognize general changes in recipient condition, which may indicate inability to receive medications. Examples include altered state of consciousness, inability to swallow medications, vomiting, inability to cooperate with receiving medications and other similar conditions. Recognize that all such conditions shall be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(10) Safely provide medications for all ages of recipients according to the following routes: oral, topical, inhalation and instillation as referenced in section 005.

(11) Recognize the limits and conditions by which a medication aide or other unlicensed person may provide medications.

(12) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a vulnerable adult has been subjected to abuse or conditions or circumstances which would result in abuse in accordance with Neb. Rev. Stat. 28-372.

(13) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a child has been subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which reasonably would result in abuse or neglect in accordance with Neb. Rev. Stat. 28-711.

(14) Recognize the recipient's property rights and physical boundaries.

The regulations relating to medication aides specify that direction and monitoring of the medication administration completed by medication aides will be completed on an ongoing basis. The DD provider agency must have policies and procedures in place for monitoring medication administration by medication aides.

State Statute 71-1132.01 to 71-1132.53, the Nurse Practice Act also applies. The Nurse Practice Act specifies that practice of nursing by a registered nurse means assuming responsibility and accountability for nursing actions which include delegating, directing, or assigning nursing interventions that may be performed by others, and do not conflict with the Act.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five rights (Provides the right medication, to the right person, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Medication errors must be reported to the person responsible for providing directions and monitoring. This person could be a recipient with capability and capacity to make informed decision about medications for his/her medication (i.e. self-administration), a caretaker, or a licensed health care professional.

Medication errors suspected to be abuse or neglect must be reported to DHHS Protection and Safety Services or law enforcement.

Medication errors are any violation of the "five rights" - providing the right medication, to the right person, at the right time, in the right dose, and by the right route, or inaccurate documentation of medication name, dose, route, and/or time administered.

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement. The provider's QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:
a. Review and approval of each DD provider's policies and procedures during the provider initial certification process;
b. On-site certification review activities; and
c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDS program staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DDD. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of individuals served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including persons prescribed behavior modifying medication. The sample size ranges based on the number of individuals served at the site; however, it is never of only 1 person and always includes at least 3. From this certification review, it would be determined whether or not individuals receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff, a DD Surveyor, cites deficient practice in the certification report and the provider agency must submit formal Plan of Improvement (POI) addressing citations. The POI must be approved by DDD, and the provider is advised of changes that may be necessary to the POI. The POI must comply with regulatory requirements (404 NAC 4-002.10B) and be approved by DDD. The provider is advised of changes that may be necessary to the POI and upon receipt of an acceptable plan of improvement, the DDD may conduct an on-site revisit or request information form the provider to ensure resolution is completed.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. Upon request by DPH, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry.

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of performance errors by individual Medication Aides and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry. Individual errors are not aggregated by DPH.

DDD service coordination monitors the implementation of the IPP, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review -

completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual IPP and semi-annual IPP. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed verbally at the time of the discovery or in writing in a service review report.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Out of the total number of monitorings, at the time of the monitoring, the number of persons free from abuse and neglect.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordination Monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the local QA/QI committee or the state DDD QI committee

Performance Measure:
Out of the total number of service coordination monitorings, the number of neglect and abuse allegations that were followed up by the DD provider.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service Coordination Monitoring

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the local QA/QI committee or the state DDD QI committee

Performance Measure:
Out of the total number of reported incidents of suspected abuse/neglect, the number reported within the required timeframe.

Data Source (Select one):
Other
If 'Other' is selected, specify:
incident reports

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Nebraska state statute 83-1202 states that it is the intent of the Legislature that "The first priority of the state in responding to the needs of persons with developmental disabilities should be to ensure that all such persons have sufficient food, housing, clothing, medical care, protections from abuse or neglect, and protection from harm." State regulations require that individuals have the same legal rights and responsibilities guaranteed to all other individuals under the federal and state constitutions and federal and state laws. State statute 83-1216 and state regulations also require that all DD providers who will provide direct contact services undergo background and criminal history checks. DHHS also adhere to state statute by completing background and criminal history checks prior to hiring DDD service coordinators.

Information concerning protections from abuse, neglect, and exploitation is provided to participants and his/her legal representative prior to the initiation of services and annually thereafter. Waiver participants may contact DHHS Protective Services or law enforcement directly to report suspected abuse, neglect, and exploitation. They may also tell their DDD service coordinator (SC), a trusted friend or family member who will report the suspected abuse or neglect on the participant's behalf. Suspected abuse and neglect may be reported by a toll free abuse and neglect hotline that is available 24/7 and posted on the DHHS website. Reports of suspected abuse and neglect are also accepted by e-mail, FAX, or letter. Allegations of abuse, neglect, and exploitation reported to the toll-free 24 hour hotline are tracked by DHHS.

Nebraska DD providers have had to complete and provide Service Coordination with incident reports for a number of years. Under state policies, all incidents, including allegations of abuse and neglect reportable under Nebraska state statutes are currently required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using DDD's online reporting system within 24 hours of the phone call.

While online incident reporting has been in place for several months, plans are to have a statewide-integrated online DD system for individual records, monitoring, and reporting purposes.

DDD staff triage the APS/CPS and incident reports daily and determine the appropriate response which depends upon the type and frequency of the incident. When warranted follow-up on individual incidents is completed to gather more information or request clarification.

As a part of SC monitoring, the expectation is to track reportable incidents by person and by provider to look at trends in incidents and to provide better information to the individual teams to aid defining needed supports for persons.

Service Coordination enters the incident reports into a database, and an aggregate report of these incidents is prepared for the state DDD QI on a semi-annual basis. The state QI committee reviews the reports and makes recommendations if necessary.

Since 1992, Nebraska has had a Death Review Committee to review deaths of persons served by DD habilitative providers. The Death Review Committee membership includes a physician, nurse, and administrative representative from DHHS DDD.

Nebraska's Death Review Committee reviews information submitted by specialized providers of service relative to the death of persons whose services are funded by the State of Nebraska. This is done in an effort to determine trends or individual situations which may indicate training and/or education needs and to provide information to service providers regarding best practices and prevention. The Death Review Committee also reviews of deaths of persons whose services are provided by non-specialized providers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The State has set up processes to address individual problems as they are discovered.

SC Supervisors conduct a review of every IFSP (100% sample) and additional evidence of the process to ensure the IFSP reflects the individual's directions, preferences, and personal and career goals, the IFSP is based on adequate assessments of their abilities, and that health and safety issues are addressed. When variances are noted, the SC Supervisor oversees the action taken by the SC to correct the IFSP.

Service Coordination monitors the implementation of the IFSP to ensure the timely and efficacious delivery of all services specified in the IFSP for the person. Full reviews are conducted within 60 days of the annual and semi-annual IFSPs. Additional monitoring tools specific to behavioral, medical, or nutritional needs of a particular individual are utilized on a schedule determined by the IFSP team or DDD central office. The full reviews consist of checking on 49 items grouped into seven groupings – rights, habilitation, financial, service needs, health and safety, home/work environment, and individual's input which utilizes the core questions from the Personal Experience Survey.

The SC monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC conducts ongoing monitoring, called partial reviews. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the consumer, their family, or others. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

When issues or problems are discovered during a SC monitoring, the individual's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the individual, manager of services, and/or providers, etc. A timeline to address the issues and/or an IFSP team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

To allow for state oversight of the SC monitoring process, the desk review of the IFSP by the SC Supervisor is conducted with findings entered into the database. This allows individual SCs to track issues that aren't resolved and for the SC Supervisors to have access to the information in aggregate form to look at the performance of individual SCs, and provide aggregate information for the SC Supervisors, local Service Coordination District Administrators, and the central office. This information is reviewed and acted on, as appropriate, at the state or local level.

The aggregate information is summarized and reviewed by the DDD QI Committee quarterly. The summarized data for the IFSP review is also shared with Service Coordination District Administrators at the local service district level.

By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. In addition, certified providers are required to verbally report to the individual SC incidents immediately upon the provider becoming aware of the incident. The verbal reports are followed up with online reports within 24 hours of the verbal report being made. DDD staff triage the reports daily and determine the appropriate response which depends upon the type and frequency of the incident. See G-1.b. for information on the type of incidents which must be reported.

DDD receives automated alerts on calls made to the DHHS "hotline" for reporting alleged abuse/neglect. DDD staff triage/review the information and make a determination whether the incident reported to the hotline needs to be addressed by DDD Administration. Depending on the severity of the incident, the response by DDD ranges from recording the incident in a tracking database to conducting a complaint investigation.

A database of these incidents is kept by DDD. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on an individual and provider wide level to address the issue and to decrease the likelihood of future incidents. A summary of all the incidents are compiled into a report reviewed quarterly by the DDD QI committee.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the DDD QI committee, DDD Deputy Administrator, or Manager for QI

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Introduction:
The Nebraska Department of Health and Human Services (DHHS) is the Single State Medicaid Agency. The State Medicaid Director is in the Division of Medicaid and Long Term Care Services. The State Medicaid Director has the ultimate authority for all of Nebraska's Medicaid services.

The quality improvement strategy for Nebraska covers all services funded by the DHHS-DDD, including the services offered under the HCBS waivers for adults (0394, 0396) and children (4154) with developmental disabilities as well as services funded by state general funds only. Nebraska's QI strategies include stratifying information for each respective waiver.

DHHS DDD, within the single State Medicaid agency, operates the Home and Community Based Services (HCBS) waivers for adults and children with developmental disabilities. DHHS staff enroll independent providers to deliver non-specialized services and community supports to eligible individuals. DHHS DDD formally certifies DD community based provider agencies and DDD contracts with certified DD provider agencies, to deliver specialized habilitation services. The Division has a formalized review process conducted by designated DDD staff to determine eligibility of individuals for the waivers. An individual's eligibility for waiver services is established on an initial and annual basis.

The Division's quality assurance efforts include a system to effectively monitor community-based placements and programs with appropriate protections, services, and supports. This is partially accomplished through active monitoring for individuals in services through local Service Coordination offices.

In order to assure protections, services, and supports on a systems level, the Division has established a formal certification and review process in accordance with state regulations, contract specifications, and state waiver requirements for provider agencies providing specialized services. This certification process includes certification and service reviews of community-based providers and programs by DDD Surveyor/Consultants, which are scheduled in accordance with the initial provisional issued for newly certified agencies, as well as the 1-year or 2-year certifications issued by the Division. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths in specialized services provided on a statewide level. In order to ensure continued certification as a provider of DD specialized services, a formal plan of improvement is required to ensure remediation of review findings that need to be addressed. On an ongoing basis, incidents and complaints associated with certified providers which have been reported to the Division are reviewed and appropriate levels of follow-up are conducted.

Philosophy:
The Nebraska DDD QI system initiates self-auditing and self-correcting processes to assure the sustainability of regulatory compliance, and the flexibility to pursue excellence in service to people with developmental disabilities. The performance measures of the Home and Community-Based Services (HCBS) waivers provide a quality framework that focuses on participant-centered desired outcomes addressed through discovery, remediation, and continuous improvement. In addition, requirements and recommendations associated with the DOJ Agreement with Nebraska contribute to this plan.

Outline/Overview of the QI Process:
The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) offers a variety of services and supports intended to allow individuals with intellectual or developmental disabilities (I/DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. A combination of non-specialized and specialized services are offered under the waivers for adults, and children and their families as appropriate, to allow choice and flexibility for individuals to purchase the services and supports that only that person may need or prefer. Non-specialized services to provide support in community living are services directed by the individual or family/advocate and delivered primarily by independent providers. These self-directed, or participant-directed, services are intended to give the individual more control over the type of services received as well as control of the providers of those services. Specialized services are habilitation services that provide residential and day habilitative training and are delivered by contracted certified DD community-based agency providers.

Responsibility for Oversight of QI:
The DDD QI efforts for Community Bases Services are coordinated through the DDD QI Committee (QIC) comprised of representatives from DDD Central Office, DHHS Licensure Unit, DHHS Medicaid, and DDD Service Coordination. The Division QI Committee meets on a quarterly basis and reviews aggregate data for statewide monitoring and certification to identify trends and consider statewide changes that will support service improvement. The committee also reviews data and reports on, including but not limited to: HCBS waiver service requirements, incidents, complaints, investigations, certification and review surveys, and related information reported by other DHHS divisions.

Specifically, quality reports include: participant experience survey data, death review data, eligibility data, supervisory IFSP review data, SC monitoring data, DDD complaint data, incident data, central office certification activity reports, quality review team reports, DPH complaint data, and team behavioral consultation reports.
The following DDD QI Committee Report List provides the name of the report and time frame for reviewing the report:
Personal Experience Survey (PES) – annually
Waiver Eligibility - semi-annually
Death Review Committee - semi-annually
Supervisory IFSP Review for waiver compliance - quarterly
Service Coordination monitoring of implementation of the IFSP - quarterly
DD Complaints - semi-annually
Incident Reports - quarterly
Certification reviews - quarterly
DPH complaints – semi-annually
Quality Review Teams - quarterly
Team Behavioral Consultation activities - annually

The minutes show review of results, recommendations for remediation, and follow-up of recommendations or assigned tasks to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

The applicable reports are shared following the committee meeting. The reports are shared with the DD service coordination administrators, other DDD central office staff, and at local staff meetings. Requests for follow-up of committee recommendations are sent out via e-mail to the appropriate state staff within the timelines assigned at the committee meetings. The QI activities of DDD and results of reports are communicated by DDD management during monthly or quarterly meetings with provider organizations, the DDD Advisory Committee, and the Nebraska DD Council.

As a result of committee review, recommendations for action are submitted to the Community Based Services Administrator. The QIC reviews follow-up on actions which are implemented as a result of recommendations.

ii. System Improvement Activities

Responsible Party*(check each that applies)*:	**Frequency of Monitoring and Analysis***(check each that applies)*:
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: semi-annually or as determined by the state DDD QI committee

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Program/Service Delivery Effectiveness:
Effectiveness is measured through dimensions of service quality including accessibility, availability, efficiency, accuracy, continuity, safety, timeliness, respectfulness, and other dimensions as appropriate.
The DDD framework of QI system monitoring and analysis consists of PLAN, DO, CHECK, and ACT.
PLAN:
What is Being Measured?

Why is it Being Measured?
What is the Data Source?
Who is Responsible?

DO:
What Will Be Done/How/Frequency?
How Will Data Be Collected (& by whom)?
How/Who Will Aggregate the Data and Generate Reports?
In What Format Will Data Be Reported?

CHECK:
Who/When Will Results be Reviewed and Interpreted?
To Whom Will Recommendations be Made/Timeframes?

ACT:
Who Will Implement/Over-See Recommended Changes?
Data is aggregated through queries from systems where data is entered directly by the worker or reporter. These systems include Info Path, SAS, N-FOCUS, Therap, Share Point, and OnBase. For data that is not entered directly into a system, data is derived from individual source documents such as audits of files or certification reports, and manually tabulated as necessary.

Reports reflect data and information in charts, graphs, tables, and narrative formats. QI Committee minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures. The activities of the QI committees are reported verbally to the service coordination administrators, DDD central office staff, and at local staff meetings, and are recorded in the minutes of each meeting. Requests for follow-up of committee recommendations are sent out via e-mail to the appropriate state staff within the timelines assigned at the committee meetings.

A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The following DDD QI Committee Report List provides the name of the report and time frame for reviewing the report:
Personal Experience Survey (PES) – annually
Waiver Eligibility - semi-annually
Death Review Committee - semi-annually
Supervisory IFSP Review for waiver compliance - quarterly
Service Coordination monitoring of implementation of the IFSP - quarterly
DD Complaints - semi-annually
Incident Reports - quarterly
Certification reviews - quarterly
DPH complaints – semi-annually
Quality Review Teams - quarterly
Team Behavioral Consultation activities - annually

Aggregate data is shared through the QI Committee with DD Administrative staff, Service Coordination, and other stakeholders. Data reports are submitted as requested to CMS Waiver representatives and the Department of Justice Independent Expert.

The QI activities of DDD and results of reports may be communicated by DDD management during monthly or quarterly meetings with provider organizations, the DDD Advisory Committee, the Nebraska DD Council, and DDD-sponsored meetings for individuals, families, and other interested parties

Data is reviewed on at least a quarterly basis through the QI Committee and DD Administration. Appropriate recommendations, action plans, and follow-up are included within the QI Committee minutes.

The DDD central office management team is responsible for coordinating the monitoring and analysis of system design changes. The management team works in conjunction with the QI committee and the program staff to develop methods of evaluation when implementing system design changes. The goal is to clearly define the outcome desired as a function of the system change and to allow the gathering of data and other information related to the state of affairs prior to the system change.

In cases where this is not reasonably possible, efforts are made to develop alternate strategies to capture information post hoc that will allow a determination of whether the outcome was met. In those cases, it is more difficult to attribute the outcome measurement directly to the systems changes than when adequate baseline measures can be compared to measures taken following the system change.

An example of the development and monitoring of systems changes strategies can be provided. An example of a system change was the decision to transfer responsibility for certification activities and complaint investigations from the Division of Public Health (DPH) to the DDD in October 2010. A ninety-day transition period was planned with the outcomes clearly defined – shift responsibilities from one division to another division within the Medicaid agency; have a stronger presence in the community; respond quickly to complaints; and realigns the statutory accountability and oversight under the Division of DD. Processes for initial certification had to be revised quickly to incorporate responsibilities performed by DPH; additional staff were hired; training on complaint investigation and compliance review techniques was provided, and indicators for the need for further action were developed within the ninety-day transition. The quarterly report on certification activities and the semi-annual report on complaint investigations provide information to the QI committee for evaluation of additional systems changes related to certification activities and complaint investigations.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement strategy for Nebraska covers all services funded by the DHHS-DDD, including the services offered under the HCBS waivers for adults (0394, 0396) and children (4154) with developmental disabilities as well as services funded by state general funds only. Nebraska's QI strategies include stratifying information for each respective waiver.

Contributors to the assessment of the QI process can be determined through CMS audit and onsite visit reports and findings. In addition, effectiveness is also measured through the relevancy that collected data has in providing useful information on the timeliness and quality of services provided through Community Based Services.

The Quality Improvement Strategy is evaluated on various levels in a relatively systematic basis. Information reviewed by the QI committee is scrutinized to assess the reliability and thus, validity of the information being presented each time a committee meeting is held.

An on-line reporting and tracking method for critical events or incidents was implemented in April 2011 to allow for coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. DDD also utilizes the Document Library in SharePoint, an intranet application of the Microsoft Outlook software, to store current forms, policies, and procedures. This allows utilization by service coordination and central office staff.

All metadata is organized to allow for stratification by each perspective waiver. This will allow the DDD administration to access the information as needed in a more efficacious manner.

There is also a self-correcting nature based on strategies used to affect systems change. As the QIS becomes more mature, the development of remediation strategies becomes influenced by the history of prior efforts. The historical access to and cooperation with various levels of personnel and resources as well as the efficacy of historical strategies all influence the development of new remediation strategies. The QI strategies are evaluated at a minimum once during the waiver period and prior to renewal.

New technology may also lead to system changes and improvements in quality improvement strategies. As new and updated web applications become available, data and processes for gathering and analyzing data are reviewed and may lead to new strategies.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial accountability, or integrity, is a joint responsibility of the DDD with assistance from the DHHS Operations.

Checks and balances are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The individual's SC initiates and submits the electronic

authorization to their supervisor and disability services specialist (DSS) who review and approve it and electronically submit the authorization to DDD central office for entry into NFOCUS, the state's current electronic authorization, and payment system. When the DSS completes the annual waiver redetermination and when the SC's Supervisor completes the IFSP review, the authorization on NFOCUS is matched with the paper authorization and the information in the IFSP. When discrepancies are found, the SC, SC supervisor, or the DSS take action to correct errors in the authorization by submitting a new authorization with a change in the provider, service type, service amount, and/or dates of services.

An independent statewide single audit of DHHS is conducted by the State Auditor of Public Accounts (APA) office on an annual basis following each state fiscal year (July 1 – June 30). This is an audit of the financial statements of the governmental activities, the business-type activities, the aggregate discreetly presented component units, each major fund, and the aggregate remaining fund information of the State of Nebraska. The final report includes APA's findings, DHHS management responses, and corrective action plans, if applicable. Financial services staff respond to findings related to the State's accounting systems. DDD staff responds to findings related to review of randomly selected individual waiver files.

The APA reviews the waiver files for compliance with the states regulations. Each electronic waiver file must include the waiver consent form, IFSP, documentation of annual physical exam, service authorization form, and waiver review worksheets. The APA office also requests a copy of the billing document and NFOCUS provider authorization that corresponds with the service dates being tested. The authorization and billing documents are checked for accuracy of service codes and service rates, as well as for agreement with the IFSP documentation.

DDD is responsible to ensure the integrity of the day-to-day authorization and claims processes. DDD staff authorizes services, verify individual claims, correct suspended claims, and track the participant's utilization of waiver services. DDD staff may conduct financial reviews of provider claims when concern is raised through monitoring, certification activities, or complaint investigations.

Financial Services within Operations tracks audit reports, operates the cost allocation plan, prepares, and monitors budget projections for the Division of Medicaid and Long-Term Care and DDD, prepare federal and state reports as required, and prepare the CMS-64 and 372 reports.

(a) DD agency providers are required by contract to do an annual audit of their operations. These are submitted to Financial Services and are reviewed by an analyst for any audit findings or exceptions that might impact on State payments by or for the provider.

Services that are delivered by independent individual providers rather than provider agencies do not require an independent audit. Independent individual providers are required to retain financial and statistical records to support and document all claims.

(b) DDD staff and the NFOCUS electronic authorization and payment system do a pre-audit of all provider claims to assure the accuracy of coding and billing.
Independent non-specialized providers must document on a calendar or separate piece of paper, the type of service provided, the times each service was provided, and the dates the service(s) were provided to each individual. This calendar is submitted to the individual, along with the billing, or claim for services. The individual, legal guardian or representative verifies the accuracy of the claim by reviewing and signing the calendar. The calendar and provider claim are then submitted to DHHS staff.

DD provider agencies submit multi-individual claims to DHHS staff without supporting documentation. However, supporting documentation, including staff timecards, individual attendance records or activity schedules, program data records, or other documentation as determined by DDD must be available to DDD staff upon request. The agency must maintain records and documentation in sufficient detail, such as staff timesheets and location of service provision, to allow state staff to verify units of service provided to individuals as certified on the monthly billing document.

Prior to submitting the claim for payment, local DHHS staff is responsible to review the units of services billed by the providers. DHHS staff may provide assistance to providers regarding billing and the codes for billing. As a part of the efforts to ensure accurate billing, Suspended DD Claims Reports are generated for billings that do not match the authorizations for service. DDD Central Office staff review these claims and make adjustments to ensure accurate billing.

Individual audits of provider claims may be conducted in response to concerns raised by complaints or certification or licensure reviews. DD central office staff will review documentation to support the claim for services. This documentation may include, but is not limited to, the provider calendar and corresponding claim, agency staff time sheets and corresponding claims, service authorizations, service coordination tracking of the utilization of services, and the IFSP. When issues are found that may be considered fraudulent claims; those issues are referred to the DHHS Medicaid Surveillance and Utilization Review Unit, or the Medicaid Fraud Control Unit of the Nebraska Department of Justice Office of the Attorney General.

DDD also conducts internal quality assurance activities related to the use of funding. Billing and authorization data is queried to track trends in costs and service use by area, provider and statewide.

Financial Services track the use of Medicaid funding and provide monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of efforts to enhance our monitoring and oversight of the use of waiver funding.

(c) The State of Nebraska has a statewide single audit of DHHS conducted on an annual basis. The Auditor of Public Accounts, an independent State agency, conducts this independent single audit

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the waiver application.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service authorizations

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by state DDD QI committee

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Financial accountability is a joint responsibility of the DHHS - DDD with assistance from Financial Services staff within DHHS Operations.

The following controls are currently employed to ensure payments are made only for services rendered:
1. The need for the service is documented in the IFSP;
2. DHHS staff have enrolled, certified, and/or contracted with the waiver provider and prior-authorized each waiver service to be delivered;
3. When services are delivered by an independent provider, a calendar is completed, listing the date of service(s), the specific task(s), and the times of service, and signed by the waiver participant or designee, verifying the services have been delivered as claimed and a calendar and claim are submitted for approval;
5. DHHS staff review the claim and submit claim to DHHS claims processing staff for processing; and
6. Edits are in place in the computer system.

A pre-audit of all specialized provider agency claims is completed to assure the accuracy of coding and claim. Prior to submitting claims to Financial Services for processing, DDD Service Coordination is responsible to review the units of services billed by the providers.

NFOCUS, Nebraska's current electronic system for authorization and claims processing, was designed to meet the CMS requirements and the HCBS waiver specifications. The system also completes a pre-audit of all claims as a part of the efforts to ensure accurate claims. A claim must include: The provider that provided the service, the person who received the service, the service authorization identification number, the service type, the dates of service, the frequency and rate authorized for the service, the actual number of units provided for the stated time period and the total amount claimed. When a claim is submitted and entered into NFOCUS, the system validates all submitted information against the service authorization on file. Edits are built into NFOCUS to audit the service authorization time period, the claim time period, the number of remaining authorized units, and math computations. Claims that fail to pass validation or auditing are suspended from processing for review by DDD central office staff charged with the responsibility for correcting errors and/or requesting additional information necessary to resolve the error. On a daily basis Suspended Claims Reports are generated for provider claims that do not match the authorizations for service. Claims that pass this validation are approved for payment.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the State's current electronic accounting system, the Nebraska Information System (NIS).

DDD also conducts internal QI activities related to the use of DDD funding. Claim and authorization data is queried to track trends in costs and service use by area, provider and statewide.

Financial Services tracks the use of Medicaid funding and provides monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of our efforts to enhance our monitoring and oversight of the use of waiver funding.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individuals who have chosen to participate and receive waiver services are notified in writing by DHHS staff of the authorized funding amount at the time of choosing a provider and in the development of the IFSP. Checks and balances are in place to assure accurate authorizations. The team determines the provider, amount, and type of services needed. The individual's SC initiates and submits the electronic authorization to their supervisor and disability services specialist (DSS) who review and approve it and electronically submit the authorization to DDD central office for entry into NFOCUS, the state's current electronic authorization, and payment system. When the DSS completes the annual waiver redetermination and when the SC's Supervisor completes the IFSP review, the authorization on NFOCUS is matched with the paper authorization and the information in the IFSP. When discrepancies are found, the SC, SC supervisor, or the DSS take action to correct errors in the authorization by submitting a new authorization with a change in the provider, service type, service amount, and/or dates of services. A pre-audit of all individual specialized provider claims is completed to assure the accuracy of coding and claim. Prior to submitting claims to Financial Services for processing, DDD Service Coordination is responsible to review the provider calendar if applicable and claim document that includes the units of services billed by the providers. NFOCUS, Nebraska's current electronic system for authorization and claims processing, was designed to meet the CMS requirements and the HCBS DD waiver specifications. The system also completes a pre-audit of all claims as a part of the efforts to ensure accurate claims.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the state DDD QI committee

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Using the normal budgeting and appropriation process, the Legislature and Governor determine the appropriation level for the DD Aid budget program. The Nebraska Legislature appropriates funding for services, specifying the percentage of increase each budget year, or specifying how a special appropriation is to be spent. The increase in appropriation or a special designation determines the rate increase. DHHS determines the rates, and communicates these rates to the Governor's budget staff and to the Nebraska Legislature's Appropriation Committee.

Public hearings are held to provide opportunities for public comment on the Legislative Appropriations Bill. Dates of the hearings are posted on the Nebraska Legislative website, major newspapers in the state, and at the Nebraska State Capital or other state and public buildings in which the hearings are held. This waiver is a fee for service waiver.

In 2009, the Legislature approved a special appropriation for an assessment of the rate structure for DD services. The rates are based on a study on the actual costs of services conducted by a national consulting firm in 2010 and 2011. A number of tasks were completed to develop rates for services provided under the HCBS waivers 0394, 0396, and 4154. The consulting firm examined DDD's historical payment methodology, met with providers and surveyed stakeholders to gather public feedback about the current system, collected current cost and wage data from providers, utilized Bureau of Labor Statistics wage data, and researched rate methodologies used by other states.

In general, the model uses assumptions about types of employees, staffing levels, wage rates, benefits and administrative overhead ratios, vacancy rates for both employees and participants, and productivity factors. Rates include an FTE productivity factor of 1.15 (320 hours out of 2080 hours annually), based on the hours for absences due to vacation, sick time, holidays, training, administrative meetings, and activities.

Rates include non-direct cost allocation factors for taxes and benefits for each FTE, determining that the benefits factor is equal to 27.81% of total direct wage expenses. The current non-direct cost allocation factors are: Administration – 35.04%; Non-program contracted services – 3.27%; and program support – 36.0%. The cost of transportation is a non-direct cost allocation that is included in the rates.

The methodology assumes a 1:9 ratio of supervisor to direct staff oversight. Hourly and daily rates assume a direct service staff and supervisor oversight.

Hourly rates are based on one clock hour of service.

All residential rates assume resident sick leave and holidays of 15 eight-hour days in a year.

All daily residential rates begin with the assumption of 168 hours in a 7-day week with 35 hours spent outside of the residence. The remainder is 133 hours in the residence during a 7-day week.

Hourly and daily rates for day habilitation services assume a direct service staff and supervisor oversight. Hourly rates are based on 1 hour of service and the total number of hours assumed for daily rate is 4 or more. A 110 percent adjustment factor was applied to Integrated Community Employment and a 105 % adjustment factor was applied to Vocational Planning because these are services that DDD promotes.

Rates for Group Home Residential setting or continuous Companion Home Residential setting are fixed based upon the required staffing levels and allow for asleep overnight staff, awake overnight staff, or no overnight staff. Eight hours of overnight staffing are built into the overnight awake and overnight asleep rate for Group Home Residential habilitation, Extended Family Home residential habilitation, and Companion Home residential habilitation. The need for and intensity of direct staff support during 8 overnight hours is commensurate with the needs of the individual. The need for asleep overnight staff, awake overnight staff, or no overnight staff, and, as applicable, the type of awake overnight supervision or assistance that is required must be documented in each individual's service plan. When the individual does not require overnight staff, the results of an assessment to determine skills of independence must also be recorded in the service plan.

Payments are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

The methodology incorporates fixed hourly and daily rates for Day Habilitation, Workstation habilitation, Respite, Group Home Residential habilitation, Extended Family Home residential habilitation, and Companion Home residential habilitation.

The methodology incorporates only fixed hourly rates for In-home residential habilitation, Integrated Community Employment, and Vocational Planning habilitation. The hourly rate includes a direct staff person and supervisor component in the base direct care cost, which takes into consideration benefits factors, non-direct cost allocation, FTE productivity factors, supervision span of control, residential rates or day rates, staffing ratios, and adjustment factors.

Day Habilitation and workstation habilitation are continuous day services. When 4 or more hours of continuous day services are delivered in a typical workday within a usual forty-hour workweek, Monday - Friday, the provider of continuous day services may bill a daily rate. When less than 4 hours of continuous day services are delivered, reimbursement is at an hourly rate.

Group home residential habilitation, companion home residential habilitation, and extended family home residential habilitation are continuous residential services. When 4 or more hours of continuous residential services are delivered in one calendar day, Monday – Sunday, the provider of continuous residential services may bill a daily rate. When less than 4 hours of continuous residential services are delivered in a 24-hour period, Monday - Sunday, reimbursement is at an hourly rate.

When both continuous and intermittent services are delivered during day service hours, which are typically during a 40-hour workweek, reimbursement is at an hourly rate.
The Behavioral Risk and Medical Risk service rates are both a fixed daily rate and were developed by the consulting firm based on input from provider agencies that were providing this service as a pilot service. The Behavioral Risk service rate includes reimbursement for supervising practitioner consultation, direct support staff and supervisor salaries and benefits, transportation services to and from community settings for persons for the purpose of receiving day habilitation (teaching and supporting) services, and management and overhead costs. The rate also incorporates "difficulty of support" factors, which are intensive behavioral supports, and ongoing safety supervision and supports.

The Medical Risk service rate includes reimbursement for services provided by a Registered Nurse, direct support staff and supervisor salaries and benefits, transportation services to and from community settings for persons for the purpose of receiving day habilitation services, and management and overhead costs. The rate also incorporates "difficulty of care" factors, such as but not limited to development of nursing plans, provision of complex medical treatments, training unlicensed direct support professionals, and oversight of delegation of health maintenance activities to the

extent permitted under applicable state laws.

The Behavioral Risk and Medical risk services are reimbursed on a daily rate basis of 13.33 hours, and the staffing ratios are flexible and commensurate to meeting the needs of the individual.

The Team Behavioral Consultation (TBC) service rate is a cost adjustment model and includes staff salaries, benefits, and preparation time to review information and schedule the site visit; travel time which varies from 2 to 9 hours one way; on-site time, which includes a preliminary meeting, observing the individual during all awake hours in all settings; and follow-up time, which includes providing report of consultation, conference calls or meetings as necessary, and post recommendation surveys. The rate of this service is adjusted annually, based on the previous year's cost of delivering team behavioral consultation.

The hourly rates for Respite services and Community Living and Day Supports (CLDS) delivered by independent providers are based on usual and customary rates for independent providers funded through other DHHS programs. DHHS is responsible for issuing a guideline for the range of rates for Respite services and CLDS.

The authorized annual funding amount for Home Modifications is limited to $5,000. The rate for Home Modificationis based on usual and customary rates for independent providers funded through other DHHS programs. DHHS is responsible for setting the rates.

The rates for Habilitative Child Care and Homemaker services are based on usual and customary rates for independent providers funded through other DHHS programs and current data. DHHS is responsible for setting the rates.

Information about payment rates is made available verbally and in writing to waiver participants and providers by state DHHS staff. The waivers and rate study are posted on the DHHS public website.

The determination of funding for individuals is determined using the Objective Assessment Process as stated in statute and regulations. Funding is assigned based on an objective assessment of each person's abilities, to provide for equitable distribution of funding based on each person's assessed needs. This process has been used since 1999 for persons new to services or requesting an increase in their funding, and for all persons in services since July 1, 2014. Funding for Team Behavioral Consultation, Respite, Medical Risk service, and Behavioral Risk service, and Home Modification is not determined using an objective assessment process (OAP).

The assessment to ascertain each person's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). State staff completes the ICAP assessment with input from the individual's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation. This assessment is submitted to the DDD Central Office where the overall score is determined. An ICAP is completed for persons new to services, when a person adds either day or residential services or when they have a significant change in supports or abilities.

Additional funding may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Based on input from the provider and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request an exception to the OAP. The amount of exception funding is determined administratively based on justification by the team of a temporary increased service need of the individual. To the base funding, determined by OAP, is added the cost of provider supports to mitigate any risks identified in clinical assessments.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow directly from providers to the State and are not routed through intermediary entities. Preprinted claim forms are generated by NFOCUS, the State's current electronic web-based claims payment system. The claim forms are completed by the provider and submitted for claims processing in the week or month following the delivery of services.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the state's accounting system, the Nebraska Information System (NIS).

All payments are processed through its N-FOCUS sub-system, a recognized component of MMIS, and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.

The program under which a claim is paid is stored on each individual claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to NIS. N-FOCUS stores the timestamp and user ID for all new or updated information related to this process.

Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the Nebraska Information System (NIS). Claims are processed on a daily basis.

Direct billing of waiver services is provided to the State. Claims made to Medicaid are documented on the CMS-64 on a quarterly basis.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) Waiver services must be prior authorized before payment is made. Authorizations are based upon a determination that the individual meets waiver eligibility criteria, that the services are identified in the approved service plan (i.e., IFSP), and that the services are not available for funding through programs funded under section 602 (16) or (17) of the Individuals with Disabilities Education Act (P.L. 94 - 142) or section 110 of the Rehabilitation Act of 1973.

(a-c) The authorization and payment process includes the following steps:
1. Waiver eligibility of the individual is determined.
2. Waiver services are identified in the IFSP.
3. Waiver service authorization is completed, indicating approved waiver services, waiver provider(s), dates of service, and authorized units of service.
4. Authorization is entered into NFOCUS.
5. Claim document indicating current authorizations is generated biweekly or monthly and issued to the waiver provider for completion.
6. Upon review by DHHS staff, claims are submitted to NFOCUS for processing. Edits in the system verify client and provider eligibility, dates of service, units of service, and rates.

(c) All providers must sign an annual contract or agreement stipulating that the provider shall maintain records and documentation in sufficient detail to allow state staff to verify units of service provided to individuals as certified on the state billing document. Each billing document must be signed by the provider, certifying that the foregoing claim is accurate and all services provided were in compliance with applicable state regulations.

When non-specialized services are delivered by an independent provider, a service calendar must be submitted with each billing document and signed by the waiver participant or, if applicable, the family member/guardian. Both the calendar and billing document are forwarded to local DHHS staff that is responsible to review the units of services billed by the providers.

The billing validation process verifies that the individual was eligible for Medicaid waiver payment on the date of service.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ◉ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  Providers receive payments directly from DHHS.

  Payments for waiver services are currently made through an electronic data system called N-FOCUS, which is a component of Nebraska's approved MMIS. N-FOCUS (Nebraska Family Online Client User System) determines eligibility and issues payments/benefits for 36 programs administered by Nebraska DHHS. All of the following functions are incorporated into the N-FOCUS application with the exception of the actual issuance of payment that is via the NIS application and is explained below.

  (a) After a client is determined to be eligible for Medicaid on N-FOCUS, a separate eligibility process is completed for eligibility for HCBS waiver services. Once waiver eligibility is established, an authorization is completed by the individual's service coordinator and the Disability Services Specialist and submitted to DDD central office, to be entered into N-FOCUS. The eligible individual, the waiver program and the waiver services are then linked to a provider approved to provide the service for the program via a Service Authorization.

  The Service Authorization specifies the individual authorized to receive the service, the provider authorized to provide the service, the program under which the service is to be provided, the specific service to be provided, the dates for which the authorization is valid, the rate, the rate frequency, and the maximum number of units for which the provider is authorized to bill. The completed Service Authorization forms the basis for future claims to be submitted.

  A claim must include: The provider that provided the service, the person who received the service, the Service Authorization identification number, the service type, the dates of service, the frequency and rate authorized for the service, the actual number of units provided for the stated time period and the total amount claimed. When a claim is submitted and entered into N-FOCUS, the system validates all submitted information against the Service Authorization on file. Claims that fail to pass validation are suspended from processing for review by a local DHHS staff or DDD central office staff charged with the responsibility for correcting errors and/or requesting additional information necessary to resolve the error. Claims that pass this validation are approved for payment.

  During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the state's current accounting system, NIS.

  (b) All payments are processed as described in item 1 above by DHHS through its N-FOCUS sub-system, and are subsequently sent to NIS.

  (c) As described in item 1 above, the program under which a claim is paid is stored on each individual claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to NIS. N-FOCUS stores the timestamp and user ID for all new or updated information related to this process.

  (d) Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to NIS. Claims are processed on a daily basis and are paid daily when the claim is received in NIS.
- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☑ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Vocational Rehabilitation Services within the Department of Education is a state government agency. Vocational Rehabilitation Services is a provider of home modifications and receives the same rates as all providers for those services.

In Nebraska, some DD provider agencies are public providers established by County Commissioners under interlocal agreements. Both private and public providers furnish Integrated Community Employment, Day habilitation, Vocational Planning habilitation, Workstation habilitation, Group Home residential habilitation, respite, Behavioral Risk, Medical Risk, Companion Home residential habilitation, Extended Family Home residential habilitation, and In-home residential habilitation, and the payment to these public providers does not differ from the amount paid to private providers.

The state ICF subcontracts with providers to deliver team behavioral consultation. The payment to the state ICF for team behavioral consultation does not differ from the payment to the subcontracted providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

  Check each that applies:

  - [ ] **Appropriation of Local Government Revenues.**

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] **Other Local Government Level Source(s) of Funds.**

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:

  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The state utilizes the Federal SSI standard as the cost of room and board. The state deducts the SSI standard from the residential rate. Individuals who receive Group Home residential habilitation, Extended Family Home residential habilitation, Medical Risk, or Behavioral Risk services pay their room and board directly to the DD provider. Room and board cost is excluded from the FFP. Room and board costs are payment for housing, food, utilities, or items of comfort or convenience, facility maintenance, upkeep or improvement. The provider informs the individual of the amount charged for room and board.

DHHS informs the individual and the provider of any share of cost the individual is responsible to pay and this SOC is deducted from the payment made to the provider. Share of Cost amounts are not included in Federal Financial Participation requests. The claims payment system has an edit for the share of cost so that it is deducted from payments made to providers, thus ensuring that the client's share of cost is not included in expenditures reported to CMS.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	46678.77	14656.00	61334.77	73461.00	3162.00	76623.00	15288.23
2	47166.21	15388.00	62554.21	76400.00	3320.00	79720.00	17165.79
3	48135.17	16158.00	64293.17	79456.00	3486.00	82942.00	18648.83
4	49180.67	16966.00	66146.67	82634.00	3661.00	86295.00	20148.33
5	49771.54	17814.00	67585.54	85939.00	3844.00	89783.00	22197.46

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care: ICF/IID
Year 1	400	400
Year 2	450	450
Year 3	475	475
Year 4	500	500
Year 5	575	575

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimate for average length of stay on the waiver is based on the most recently filed 372 (waiver year 2008).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Estimated numbers of recipients were based on the requested increase in slots for each year. We assume that the same percentage of waiver participants will access each of these services regardless of the total number of people on the waiver. We assumed no change in recipients from 11 to 12. For each subsequent year, we increase the previous year's recipients by the same percentage as the increase in waiver slots from the previous year.

Number of recipients of home modifications has historically been limited to 1 or 2 recipients per year. We assume 2 recipients per year.

Estimates for number of units per recipient assume utilization will remain at FY2010 levels throughout the renewal period.

Cost per unit estimates are based on a 5% per year increase over waiver year 2007 rates.

Estimates for number of units per recipient assume utilization will remain at FY2006 levels throughout the renewal period.

Cost per unit estimates are based on a 5% per year increase over waiver year 2007 rates.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on actual acute care expenditures for individuals on the waiver in State Fiscal year 2010. The average cost for acute care for this year was $13,293. Price increases of 5% were included for each year.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The average cost of institutional care per ICF-MR recipient was based on actual expenditures in State Fiscal year 2010. The average cost for this Fiscal year was $67,919. Price increases of 4% were included for each year.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on actual acute care expenditures for individuals in an ICF-MR in State Fiscal year 2010. The average cost for acute care for this waiver year was $2,868. Price increases of 5% were included for each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Day Habilitation	
Group Home Residential Habilitation	
Homemaker	
Integrated Community Employment - Individual Employment Support	
Respite	
Behavioral Risk Service	
Community Living and Day Supports	
Companion Home Residential Habilitation	
Extended Family Home Residential Habilitation	
Habilitative Child Care	
Home modifications	
In-Home Residential Habilitation	
Medical Risk services	
Team Behavioral Consultation	
Vocational Planning habilitation service	
Workstation habilitation services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**32448.78**
Day Habilitation	hour	49	26.00	25.47	**32448.78**	
Group Home Residential Habilitation Total:						**9188540.79**
Group Home Residential Habilitation	hour	139	2433.00	27.17	**9188540.79**	
Homemaker Total:						**107859.20**
Homemaker	hour	40	304.00	8.87	**107859.20**	
Integrated Community Employment - Individual Employment Support Total:						**13219.50**
Integrated Community Employment - Individual Employment Support	hour	10	35.00	37.77	**13219.50**	
Respite Total:						**196257.60**
Respite	hour	64	200.00	13.94	**178432.00**	
respite - day	day	16	10.00	111.41	**17825.60**	
Behavioral Risk Service Total:						**257033.00**
Behavioral Risk Service	day	2	365.00	352.10	**257033.00**	
Community Living and Day Supports Total:						**41212.92**
Community Living and Day Supports	hour	49	86.00	9.78	**41212.92**	
Companion Home Residential Habilitation Total:						**45617.04**
Companion Home Residential Habilitation	hour	24	63.00	30.17	**45617.04**	
Extended Family Home Residential Habilitation Total:						**4803465.81**
Extended Family Home Residential Habilitation	hour	93	1901.00	27.17	**4803465.81**	
Habilitative Child Care Total:						**177712.53**
Habilitative Child Care	hour	31	643.00	7.89	**157271.37**	
habilitative child care - day	day	12	27.00	63.09	**20441.16**	
Home modifications Total:						**10000.00**
Home modifications	occurence	2	1.00	5000.00	**10000.00**	
In-Home Residential Habilitation Total:						**3115867.09**
In-Home Residential Habilitation					**3115867.09**	
		GRAND TOTAL:				**18671509.36**
		Total Estimated Unduplicated Participants:				**400**
		Factor D (Divide total by number of participants):				**46678.77**
		Average Length of Stay on the Waiver:				341

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	hour	139	743.00	30.17		
Medical Risk services Total:						**323966.70**
Medical Risk services	day	2	365.00	443.79	**323966.70**	
Team Behavioral Consultation Total:						**343842.00**
Team Behavioral Consultation	occurence	34	1.00	10113.00	**343842.00**	
Vocational Planning habilitation service Total:						**7844.20**
Vocational Planning habilitation service	hour	10	26.00	30.17	**7844.20**	
Workstation habilitation services Total:						**6622.20**
Workstation habilitation services	hour	10	26.00	25.47	**6622.20**	
				GRAND TOTAL:		**18671509.36**
				Total Estimated Unduplicated Participants:		**400**
				Factor D (Divide total by number of participants):		**46678.77**
				Average Length of Stay on the Waiver:		341

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**36965.50**
Day Habilitation	hour	55	26.00	25.85	**36965.50**	
Group Home Residential Habilitation Total:						**10467933.84**
Group Home Residential Habilitation	hour	156	2433.00	27.58	**10467933.84**	
Homemaker Total:						**123120.00**
Homemaker	hour	45	304.00	9.00	**123120.00**	
Integrated Community Employment - Individual Employment Support Total:						**14760.90**
Integrated Community Employment - Individual Employment Support	hour	11	35.00	38.34	**14760.90**	
Respite Total:						**224114.40**
Respite	hour	72	200.00	14.15	**203760.00**	
respite - day	day	18	10.00	113.08	**20354.40**	
Behavioral Risk Service Total:						**260887.40**
Behavioral Risk Service	day	2	365.00	357.38	**260887.40**	
Community Living and Day Supports Total:						**46968.90**
Community Living and Day Supports	hour	55	86.00	9.93	**46968.90**	
Companion Home Residential Habilitation Total:						**52084.62**
Companion Home Residential Habilitation	hour	27	63.00	30.62	**52084.62**	
Extended Family Home Residential Habilitation Total:						**5505105.90**
Extended Family Home Residential Habilitation	hour	105	1901.00	27.58	**5505105.90**	
Habilitative Child Care Total:						**204472.17**
Habilitative Child Care	hour	35	643.00	8.01	**180265.05**	
habilitative child care - day	day	14	27.00	64.04	**24207.12**	
Home modifications Total:						**10000.00**
Home modifications	occurence	2	1.00	5000.00	**10000.00**	
In-Home Residential Habilitation Total:						**3549102.96**
In-Home Residential Habilitation	hour	156	743.00	30.62	**3549102.96**	
Medical Risk services Total:						**328828.50**
Medical Risk services	day	2	365.00	450.45	**328828.50**	
Team Behavioral Consultation Total:						**384294.00**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Team Behavioral Consultation	occurence	38	1.00	10113.00	384294.00	
Vocational Planning habilitation service Total:						8757.32
Vocational Planning habilitation service	hour	11	26.00	30.62	8757.32	
Workstation habilitation services Total:						7395.96
Workstation habilitation services						